

PSYCHOTHERAPY

SIX APPROACHES TO

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SIX APPROACHES TO PSYCHOTHERAPY

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SIX APPROACHES TO PSYCHOTHERAPY



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Preface

IT IS THE purpose of this book to present views of six current approaches to psychotherapy. This presentation is intended to provide a general introduction to the methods and principles of each of the six approaches and to serve as a review of some of the better-known techniques of handling psychological problems. Other widely used and accepted methods of psychotherapy, especially psychoanalysis, have been omitted because they involve complex and special training over a long period of time and obviously could not be presented in this brief text.

This book is not a systematic, integrated investigation of the approaches in psychotherapy. There is no special system of presentation, since the understanding of one approach is not dependent upon the understanding of another. Neither preference nor judgment is implied in the sequence of the chapters. Six approaches do not necessarily imply disagreement; a seventh chapter, therefore, has been added to indicate the possibility of the integration of approaches into a more general or eclectic view.

Because of the diversity of the approaches, it is not feasible to expect uniformity of either terminology or organization of material. In fact, each contributor was invited to state his position in the terminology and order especially applicable to, and representative of, his field. It is hoped that this method will give the reader a more unbiased view of the specific approach under study and will lessen the likelihood of his confusing one therapeutic method with another.

The book is an outgrowth of the first of the Annual Lecture Series in Psychology held at the University of Houston. The Lecture Series

included a Symposium in Psychotherapy, comprised of six well-known leaders and practitioners in the field: Frederick C. Thorne, Nicholas Hobbs, J. L. Moreno, S. R. Slavson, Norman Reider, and Lewis Wolberg, each of whom prepared part of his symposium presentation for use in book form. The integrating chapter was written by Daniel E. Sheer.

A great amount of work on the part of many persons, a number of whom are not mentioned here because of the limitations of space, has gone into the preparation of this book. The collaboration of Daniel E. Sheer and the suggestions of L. T. Callicutt have been especially helpful. Mrs. Elizabeth Weinstein assisted in the typing of the manuscript. The work of Alvin Weinstein in the preparation of the index is gratefully acknowledged. Kenneth E. Ware, Charles Moore, and Miss Janie Ellis were responsible for proofreading most of the chapters, and Mr. Ware provided much assistance with other detailed work connected with this volume.

Gratitude is expressed to the *Journal of Clinical Psychology*, the *American Psychologist*, and the *Annals of the New York Academy of Sciences* for permitting material by Frederick Thorne to be used in his chapter and to Beacon House for permission to use material from *Psychodrama*, Volume I, in the chapter by J. L. Moreno.

J. L. McCARY

University of Houston
January 1955

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SIX APPROACHES TO PSYCHOTHERAPY

Introduction

RAPIDLY EXPANDING interest in the treatment of behavior disorders and the promising results of several methods of approach have placed psychotherapy in a prominent position among the various disciplines concerned with human behavior. Many detailed descriptions have been written of one or another specific method of psychotherapy, including the techniques of its application (usually illustrated by case studies) and claims of its "superiority" over other methods. Little has been done, however, to bring several kinds of psychotherapy together in one book so that the student or the practitioner may be better able to compare one approach with another and become, to some extent, at least, better acquainted with more than one form of therapy.

It is the purpose of this book to present a view of six of the currently best known and most widely used approaches to psychotherapy. This presentation will, it is hoped, provide a general introduction to each of the six approaches and will also serve as a review of some of the better-known techniques for handling psychological problems. More discussion has been published on these six approaches than on most, although even on these there has been little enough research and evaluation. Other methods of psychotherapy—notably psychoanalysis—might have been included in a book such as this, but the scope, complexity, and difficulty of the approach preclude any attempt to condense the method into a single book, much less into a single chapter.

In order that the techniques presented here may be better understood, they should be considered, together with their development,

in a historical perspective. Actually, psychotherapy dates back to the time when verbal interaction between two persons was first used for the benefit of the emotional process of one of them. Early Babylonians, Egyptians, and Greeks used magic, music, and prayer for the specific purpose of quieting a patient and luring demons from his body, thus introducing the first purposeful psychotherapy. The Dutch physician Weyer (1515-1588), the French psychiatrist Pinel (1745-1826), and many of their contemporaries were aware of the value of kindness and humane treatment in working with mentally disturbed patients. It was not until the latter half of the nineteenth century, however, that the medical world, through the influence of Charcot, Bernheim, Janet, and especially Freud, recognized the true importance and significance of psychotherapeutic procedures. Since these early developments, there have been many ideas about what constitutes psychotherapy, its goals, and the methods to be used in gaining those goals.

It is understandable that differences in tradition and training between two groups, physicians and psychologists, and individual differences within each group would lead to the development of different methods of psychotherapy. Consequently, it is not surprising that many methods of psychotherapy have developed, all of which have been tried, sworn by, and sworn at—some more than others. From this myriad of therapeutic approaches, a few methods have emerged that seem to have greater merit than others and have, in turn, gained more popularity than others. These methods can be divided roughly into two categories—*supportive* and *reconstructive*. The supportive method involves giving the patient direct assistance by such methods as persuasion, suggestion, relaxation, reassurance, and so on, whereas the reconstructive method involves more intensive work that seeks to effect a permanent reorganization in the patient's personality structure. Some of the therapeutic methods included in each of these categories are listed on the facing page.

Supportive Methods

1. Bibliotherapy
2. Color therapy
3. Conditioned-reflex therapy
4. Correction of physical defects
5. Dance therapy
6. Desensitization
7. Environmental manipulation
8. Hypnotherapy
9. Inspirational group therapy
10. Motivational procedures
(such as rewards and punishments)
11. Music therapy
12. Narcotherapy
13. Negative practice
14. Occupational therapy
15. Persuasion and reasoning
16. Physiotherapy
17. Placebos
18. Pressure and coercion
19. Progressive relaxation
20. Reassurance
21. Recreation
22. Re-education
23. Religious approaches
24. Rest
25. Suggestion and advice
26. Selected types of group therapy
27. Verbal catharsis and abreaction

Reconstructive Methods

1. Adler's individual psychology
2. Alexander's psychoanalytic therapy
3. Analytical group therapies
4. Art therapy
5. Classical psychoanalysis
6. Client-centered therapy
7. Deutsch's sector analysis
8. Federn's ego psychology
9. Ferenczi's active methods
10. General semantics
11. Gestalt therapy
12. Herzberg's activity psychotherapy
13. Horney's approach
14. Hypnoanalysis
15. Jungian analytical psychology
16. Karpman's objective psychotherapy
17. Levy's release therapy
18. Meyer's psychobiology
19. Mowrer's retraining approach
20. Narcoanalysis and narcosynthesis
21. Play therapies
22. Psychodrama
23. Puppetry psychotherapy
24. Rankian will therapy
25. Reich's character analysis
26. Rosen's direct analysis
27. Stekel's active analysis
28. Sullivan's interpersonal relationship therapy
29. Whitaker and Malone's experiential therapy

As this list indicates, psychotherapy at present comprises a large, diffuse group of methods. Moreover, it points up the fact that the psychological climate for the maturation of psychotherapy, a recent development among the more established disciplines of mental health, is healthful and invigorating. The present weather, however, is characterized by close loyalties and a too strict adherence to but one of a number of feasible approaches. Although the horizon of psychotherapy is unlimited, visibility is currently limited by the tendency of clinicians, teachers, and students to overemphasize some approaches at the expense of others.

This overemphasis is due to the failure of the clinicians, teachers, and students to recognize three major sources of errors in therapy. In the first place, they fail to understand that no single approach to psychotherapy—whether it is a theory of personality or a set of techniques for altering personality—has thus far been found that can explain the behavior of all individuals. This attitude is, of course, to be expected in view of the concepts on which these techniques are based. Various “schools” of psychology have set up their goals for psychotherapy in keeping with their own theoretical assumptions. Consequently, the goals may vary from relieving the patient’s symptoms to improving the patient’s interpersonal relationships and from increasing self-confidence and reality-facing to an adjustment to the over-all demands of society. Thus, the first major pitfall lies in assuming that a single approach is pertinent to all individuals.

The second source of error among clinicians, teachers, and students is the possible failure of a given individual with a specific problem to respond to a single type of therapy. For example, during therapy a client often requires, in the early stages of treatment, ventilation, reassurance, and other supportive measures before he begins to feel the need of a more intensive probing of his personality structure. The obvious point here is that, as the individual’s needs change in terms of his changing orientation to his problem, the techniques employed by the therapist will also need to be changed if the patient is to derive maximum benefit from the therapy.

The third source of error is the relationship between the ther-

apist and therapeutic techniques, which has not received adequate attention. Not only is there the question of the suitability of one type of therapy to several types of problems or of the suitability of one type of problem to several types of therapy; there is also the question of the suitability of the therapy to the therapist. Not all therapists can be expected to find a given therapeutic method comfortable. Since therapists differ in personality structure, need systems, and value systems, there must also be differences in the therapeutic approaches that the therapists use. Just as a therapeutic technique must be suited to the needs of a patient, it must also be suited to the needs of a therapist.

That such a situation should lead to overemphasis is understandable, since the approaches of the clinician, teacher, and student are largely determined by the specific orientation to which they are exposed during training. Many competent therapists of one approach do not know, or have only heard of, other approaches, and, although therapists may consider and discuss intellectually the merits of other forms of therapy, they may dogmatically persist in applying, studying, and teaching their one point of view. No one approach is "God-sent," and there is no single, magic formula for cure. It may be reasoned, therefore, that no single approach should be tolerated to the exclusion of all others. It should be obvious to all that different situations and different individuals in therapy may call for different actions.

It seems, then, that the major source of this error of omission lies at the training level. Students, especially graduate students, often develop a too limited view of the field of psychotherapy. Too frequently they are acquainted with only one or two approaches and ignore or never come into contact with others. The student then goes on to be a teacher or clinician and knowingly or unknowingly carries his bias with him, and a vicious circle of the exclusive approach is established and perpetuated. Thus, it becomes the professional and moral responsibility of all persons who are engaged in psychotherapy to gain a satisfactory working knowledge of several methods of psychotherapy so that they may be better able both to

recognize the most satisfactory therapeutic technique for a given problem and to apply that technique properly to the fullest advantage of the patient. The chief aim of this book is to help psychotherapists fulfill this responsibility.

The need for balanced presentation of some of the current leading approaches in psychotherapy is obvious. This book has been planned as an effort to meet the growing need for a re-examination of the various views in this widespread area. This book does not propose to produce masters of any single approach—much less of all of them; rather, it should be considered an overview of the leading *recognized* approaches, each of which is discussed by a leading exponent and therapist.

Each of the authors of the various approaches to psychotherapy presented in this book is recognized as an outstanding authority of his specific method of psychotherapy and has either developed the special approach or has studied and practiced it sufficiently to be able to present and discuss it adequately and soundly in his chapter. Each author has also set forth his views in detail in other books or professional journal articles.

Nicholas Hobbs, a former student of Carl Rogers, follows closely the client-centered approach to psychotherapy and has presented his method of psychotherapy in a section of Rogers's recent book *Client-Centered Therapy*. Lewis R. Wolberg, who has for many years been recognized as one of the leaders in the field of hypnotherapy, has given a detailed account of his approach in his two volumes of *Medical Hypnosis* and in his *Hypnoanalysis*. S. R. Slavson has explained in detail his approach to the problem of group therapy in many articles and in his books *An Introduction to Group Psychotherapy* and *Group Psychotherapy*. Norman Reider, although his ideas on psychotherapy have not heretofore been published in book form, has written many articles expressing his views. Frederick Thorne has set forth his method of counseling and psychotherapy in his exhaustive book, *Principles of Personality Counseling*. J. L. Moreno, the recognized leader in the field of psychodrama, has published several books, among which are *Psychodrama* and *Group Psychotherapy*, and many journal articles explaining his method of psychotherapy.

An attempt is made here to present in one concise volume the kernel of the detailed material dealing with the various approaches in order to give the student an adequate summary of each of the techniques. The purpose is not to deal with theoretical constructs and critical evaluations of the various theories and methods of psychotherapy but to present a general background to, and an introductory description of, the therapeutic *techniques* used by the qualified clinician at work. Although these systems are not presented in elaborate detail, the references at the end of each chapter provide the reader with sources of more detailed discussions and any necessary amplification of points discussed here, as well as with sources for the study of theory and the investigation of critical evaluations made of the theory.

This book is not a systematic, integrated investigation of the approaches in psychotherapy. There is no rigid system of presentation, and the understanding of one approach is not dependent upon the understanding of another. The order of the chapters implies neither preference nor judgment; order of presentation is random, except for the introductory chapter and the last chapter, which serves to integrate the six approaches.

Because of the diverse nature of the methods, it is not feasible to attempt uniformity of either terminology or organization of material. In fact, each contributor was invited to state his position in the terms and the order especially applicable to, and representative of, his field. It is hoped that this method will give the reader a more unbiased view of the specific approach being studied and will lessen the likelihood of confusing one therapeutic approach with another.



Client-Centered Psychotherapy

Nicholas Hobbs

Dr. Hobbs is Chairman of the Division of Guidance and Human Development and Professor of Educational Psychology, George Peabody College for Teachers; Chairman, Committee on Ethical Standards for Psychology, The American Psychological Association. He was formerly Chairman, Department of Psychology, Louisiana State University, and during World War II was Director, Army Air Forces Flexible Gunnery Research Division. A graduate of Ohio State University and former student of Carl Rogers, Dr. Hobbs is one of the foremost leaders in nondirective psychotherapy. He is author of one of the sections of Rogers's recent book, *Client-Centered Therapy*.

The client-centered approach to be discussed here stems originally from Freud, through modifications set forth by Otto Rank, Jessie Taft, and Fredrick Allen. Its present form first appeared in 1940, in a paper by Carl R. Rogers entitled "Newer Concepts of Psychotherapy." Two years later, in 1942, Rogers published his widely read *Counseling and Psychotherapy: Newer Concepts in Practice*, and the psychology professions, eager for new tools, readily accepted this psychotherapeutic approach. In the short period of time since Rogers first set forth his ideas, client-centered therapy has grown from a method of counseling to a theory of personality and an approach to human behavior and human relationships. It now includes not only counseling of adults and adolescents but play therapy with problem children and group therapy with both children and adults.

The aim of Hobbs and his associates in psychotherapy is not the solution of a specific problem but the growth of the individual in such a way that he may be able to deal with present and future problems in a better integrated, more mature fashion. Such growth should occur during the therapeutic hour as well as after. This purpose can best be accomplished, they believe, by warmth and responsiveness on the part of the counselor, by permissiveness in regard to expression of feeling, and by freedom from any type of pressure or coercion.

Client-Centered Psychotherapy

ALTHOUGH Rogers should be recognized as the person responsible for the conception of client-centered therapy and as a central figure in its development, the influence of others who are seldom identified as contributors to the theory should also be recognized. Studies of the history of ideas that have immediate impact, such as client-centered therapy has had, usually reveal a cultural readiness for the idea; other thinkers have created intellectual disaffections and expectancies, and consequently many workers are ready to abandon blunted tools and adopt new ones. The widespread acceptance of client-centered therapy, especially by psychologists, suggests a widespread readiness for such a formulation. In a scholarly article, Raskin (26) has traced some of the concepts that were antecedent to Rogers's thinking and that prepared psychologists for his ideas. That the ideas have impact is clear from an overview of the clinical journals for the past decade. Many psychotherapists have adopted client-centered therapy; others have modified their viewpoints to incorporate the features that appeal to them; and still others have registered its influence by their vigorous, and sometimes heated, opposition. Client-centered therapy is not an idea that can be ignored.

Today client-centered therapy is often contrasted with psychoanalysis, and some of the clear differences between the two viewpoints are evident in this volume. However, in broader perspective their close kinship is evident. Rosenzweig (31) has correctly classified both approaches as "active" and "dynamic," as opposed to the passive therapies, and Raskin points out some of the "nondirective"

inclinations in Freud's work. Some of Freud's emphasis on the patient as central in the therapeutic process, as well as his reservation about the idea, is evident in the following quotation:

What subject matter the treatment begins with is on the whole immaterial, whether the patient's life story, with a history of the illness or with recollections of childhood; but in any case the patient must be left to talk, and the choice of the subject left to him. One says to him, therefore, "Before I can say anything to you, I must know a great deal about you; please tell me what you know about yourself." (Freud, quoted in 26)

Freud established a number of ideas that have either been directly accepted in client-centered thinking or accepted with modifications—the modifications often being in the direction of making a more rigorous application of an idea stated tentatively or with reservation by Freud. Among shared and partly shared ideas are the use of the interview as a therapeutic instrument; the importance of unconscious motivations and of early childhood experience; the central role of anxiety in neurosis and in therapy; the critical nature of interpretation, resistance, and transference in the therapeutic process (viewed differently by the two schools, of course); and the importance of a nonmoralizing attitude on the part of the therapist.

It would be something of a tour de force to make Freud out a "nondirectivist," and such is not intended here. We know that Freud could be domineering, dogmatic, and quite impatient with the reluctance of people to accept his revelations of the truth about them. On the other hand, it seems important to point out common elements in Freudian psychoanalysis and client-centered therapy, since the two are often described in antithetical terms.

Freud's bold and insightful investigations yielded our first substantial theory of personality and our first effective technique of psychotherapy. The men who worked closely with Freud in the development of his theories broke away from him, one by one, and fashioned modifications of psychoanalysis that have followed diverging courses in their subsequent development. Otto Rank was one of

these men, and it is through him and his direct followers, Jessie Taft and Frederick Allen, that one can trace the relationship of Rogers's thinking to the original thinking of Freud. What Rogers made of Rankian ideas and what he added of his own constitute an impressive achievement that we shall examine in detail. Here are some of the concepts that provide a starting point for client-centered therapy.

Rank recognized the positive, creative, directional nature of man's striving. He spoke of "will" and rejected the notion of man pulled and pushed by impersonal forces. The neurotic is at an impasse; he is bound by conflict of positive will and fear of the consequences of willing. To will without guilt, to be oneself without fear, is the mark of health. Therapy seeks to free the person from this conflict, to assist him to gain acceptance of himself in all his uniqueness and with all his ambivalences.

To this end Rank put the patient unequivocally at the center of the therapeutic process. The therapist is available as "ego-helper"; he works on those aspects of self "felt by the patient to be disturbing" (26); he is concerned not so much with the past as with the present, not so much with the content of the patient's life as with the patient's immediate experience of living in relationship to the therapist; he avoids giving love, since this would create dependency; he makes no attempt to "educate," since this would intensify the neurotic conflict; he utilizes the time element in therapy as symbolic of life's boundaries against which protest (counter-will) is infantile and which demands an affirmative approach to living.

Real psychotherapy is not concerned primarily with adaptation to any kind of reality, but with the adjustment of the patient to himself, that is, with the acceptance of his own individuality or of that part of his personality which he has formerly denied. (Rank, quoted in 26)

Jessie Taft translated Rank's work and added richly to his ideas. One of her important contributions is the detailed reporting of two cases dealing with children, a procedure so often neglected that it is frequently impossible to tell whether the authors of therapeutic theories actually put their ideas into action. Taft elaborated on

Rank's idea concerning time in the therapeutic process as a prototype of life's limits:

. . . . one might fairly define relationship therapy as a process in which the individual finally learns to utilize the allotted hour from beginning to end without undue fear, resistance, resentment or greediness. When he can take it and also leave it without denying its value, without trying to escape it completely or keep it forever because of this very value, in so far as he has learned to live, to accept this fragment of time in and for itself, and strange as it may seem, if he can live this hour he has in his grasp the secret of all hours, he has conquered life and time for the moment and in principle. (Taft, quoted in 26)

Frederick Allen elaborated on the nature of the relationship between the client and the therapist and gave explicit statement to concepts that also emerge in client-centered therapy.*

I feel strongly that it is more important today than ever before to affirm with clarity . . . a belief in the individual's capacity to be responsible for his own direction—within the structure of the culture in which he lives The therapeutic experience is an episode in the journey of some children toward realization of the potentialities that lie within themselves The urge to grow that is universal in all living matter provides motivation for the journey The therapeutic point of view of which I have written . . . has its roots deep in a concept of individual responsibility. Its recurrent theme is that individuals can be helped to help themselves (1).

Taft and Allen write with conviction and power of a philosophy closely related to the client-centered point of view. It is to their credit, too, that they reported extensively what was said and done in therapy sessions. In reading accounts of their therapy, however, one is disappointed in the wide gap between their theory and their practice. Considerable responsibility for the direction of the interview is retained by the therapist; there is probing for material; interpretation is frequently employed (see also 40). It is as though Taft

* Allen's book on therapy with children was published in the same year as Rogers's *Counseling and Psychotherapy*. Apparently Rogers did not draw so much from Allen as both drew from common sources.

and Allen are inspired in their theory but unable to conform to its rigorous discipline in the therapy room. They frequently fall into more traditional ways of treatment. As Raskin points out, Rogers has been able to translate (as well as to extend) the philosophical concepts of individual responsibility, of respect for the integrity of the individual, and of confidence in the capacity of the individual to be responsible for himself into a therapeutic procedure that is consistent in what the therapist does and is, in large measure, standard among therapists.

The work of Rogers and others who have contributed to the development of client-centered therapy is influenced by psychoanalytic theory, as described above, and also by the experimental tradition of quantitative psychology. Perhaps one of Rogers's major contributions to the field of psychotherapy is his initial and continuing emphasis on the importance of quantitative investigations of the therapeutic process. The many researches designed to test hypotheses pertinent to client-centered theory have given us new insights into the process of therapy from one point of view. Other points of view, derived largely from clinical experience, need similar verification and correction through a quantitative check on their hypotheses. Through quantification and experimental check of many approaches to therapy, guided always, of course, by clinical intelligence, we may hope to arrive at understandings that transcend by far the best formulations of any current theory.

SOME OPERATIONS

In terms of specific operations, without consideration of rationale, what does the client-centered therapist do? Such an operational description of procedures, astringent as it is, may be more helpful at the outset than an attempt to convey a feeling for the climate of client-centered interviews or to describe the attitudes and feelings of the therapist, although many believe that these tangible aspects of relationship are more critical than the specific acts of the

therapist. The following acts appear to be characteristic of the behavior of the client-centered therapist (22, 23, 24, 28, 29):

1. The therapist attempts to understand what the client is saying with reference to content, feeling, and import to the client and to communicate this understanding to the client.
2. The therapist interprets what the client has said by offering a condensation or a synthesis of the expressed feelings.
3. The therapist simply accepts what the client has said with an implication that what he has said has been understood.
4. The therapist defines for the client, at moments when the issue is relevant from the client's point of view, the nature of the therapeutic relationship, the expectancies of the situation, and the limits of the therapist-client relationship.
5. The therapist attempts to convey to the client, through gesture, posture, and facial expression, as well as through words, a sense of acceptance and of confidence in the ability of the client to handle his problems.
6. The therapist answers questions and gives information when such responses are relevant to treatment, but he may refrain from giving information when the issue of dependency seems involved in the question.
7. The therapist actively participates in the therapy session, keeping alert, attempting to pick up nuances of feeling, interrupting the client if necessary to make certain that the therapist is understanding what the client is saying and feeling.

It is necessary to mention some of the things that the client-centered therapist does not do, especially since they are things that people rather often expect any therapist to do. The client-centered therapist does not

- interpret the behavior of the client with reference to hypotheses held by the therapist or to any theory of personality dynamics.
- attempt to promote insight directly.
- advise, moralize, praise, blame, teach, or plan programs of activities.

- complete a formal diagnostic study of the individual prior to or in the course of therapy.
- ask probing questions or suggest areas for exploration.

Experimental Findings

Such a listing as the above gives a picture of client-centered therapy but does not reflect its distinctive characteristics. All competent therapists are accepting and permissive; they reflect feelings and attempt to understand in sensitive fashion what it is that the client is saying. They have long since abandoned a moralizing attitude and other exceptionable actions found in the list above. Similarities and incisive differences are underscored by the results of two factorial studies, one involving descriptions of the ideal therapeutic relationship and the other involving the analysis of therapy protocols taken from sessions conducted by therapists with different theoretical orientations and contrasting levels of experience.

Fiedler (8, 9) first had ten persons—three analytically oriented therapists, three with a client-centered orientation, one Adlerian, and three laymen—systematically describe the ideal therapeutic relationship by sorting seventy-five statements descriptive of possible aspects of therapeutic relationships. Each judge rated the statements on a seven-point scale, thus providing a numerical indication of the extent to which he considered the statement to be characteristic of a good therapeutic relationship. The intercorrelations among the ratings of all judges, regardless of orientation or experience, were positive and generally high, ranging from .43 to .84, and indicated considerable agreement as to what constitutes an ideal relationship.

The judges agreed on the importance of ability to understand completely what the patient is saying, to follow his line of thought and make responses in line with what he is saying, to respond with understanding and sensitivity to feelings not alone with words but with expression and tone of voice, and to treat the patient as an equal partner in the solution of shared problems. It is thus clear that therapists of different persuasions can agree in describing desirable

qualities in therapeutic relationships and that, indeed, laymen can do the same. The common character of aspiration is evident, but what of behavior?

Fiedler extended his study (9) to determine what therapists of different schools actually do and made possible another revealing comparison by including in his study the work of inexperienced therapists. The electrical recordings of ten interviews by ten therapists—two Adlerians, four client-centered, and four psychoanalytically oriented, half in each group being experienced and half inexperienced—were studied by four judges, who attempted to estimate the extent to which the therapists achieved the previously described ideal. One of the most interesting findings was that there was greater similarity between the performances of experienced therapists of different orientations than there was between the experienced and the inexperienced therapists of the same orientation. Evidently experienced therapists, regardless of their theory, share certain fundamental attitudes and do many things alike.

On one issue, the client-centered therapist differed from most of the therapists with other orientations. Therapists with the client-centered orientation left more of the responsibility for the course and direction of therapy to the client. It is on this issue of responsibility—for the choice of topic, for the finding of meanings, for moving ahead or resting awhile in the comfort of old defenses, and for final resolutions—that one is likely to find client-centered therapy differing most consistently from other therapies. Thus, on important dimensions we find experienced therapists close together and on one dimension apart. This one dimension, however, is critical, and the position on the continuum taken by the therapist makes a difference that should not be minimized.

The Personal Element

Operational and quantitative definitions of a therapeutic procedure are very valuable. We greatly need more of them, and systematic progress toward more effective techniques of therapy is

likely to come only as we increase precision in the description of various processes that make up the therapeutic experience. But, at present at least, we can achieve precision in description only by describing something that no therapist or client would recognize as psychotherapy. The intensely personal element of the therapeutic relationship is squeezed out. The anxiety, the hope, the despair, the hate, the affection, the pettiness, the greatness, expressed uniquely by each client and responded to differently for each client by each therapist and differently for each client by different therapists, and the confidence, the uncertainty, the affection, the resentment, the anxiety, the satisfaction felt by the therapist from interview to interview all force us to a literary description of therapy that is somewhat better than the counted and categorized lines of the therapy protocols but in itself seems ultimately flat in comparison with the real experience. The phrases and words that we use in such literary descriptions—respect for the integrity of the individual, confidence in the capacity of the individual to be responsible for himself, commitment to the right of the individual to make his own choices, warmth and sensitivity and empathy—get worn smooth. Consequently, the important ideas that the phrases and words stand for are hardly distinguishable, until their meaning is renewed for a person by participation in the primary experiences for which they stand, experiences that can really be known only as therapist or as client.

THE PROCESS OF THERAPY *

The process of client-centered therapy has been illuminated by a number of careful investigations employing the technique of analysis of verbatim typescripts of therapy sessions taken from electrical recordings. These studies have been focused on various aspects of therapy and most frequently on changes that are observable during the full course of therapy with an individual.

* For a more detailed treatment of this topic, see Chap. 4 of Rogers (29). This discussion is based largely on that chapter.

Several studies (33, 35) have revealed characteristic movement in successful cases. They show that the client is initially concerned with a discussion of his problems and that this concern diminishes sharply during the course of therapy (from 52 percent of total client conversation in the first fifth of therapy to 29 percent in the final fifth); that he shows little insight in the beginning stages of therapy (4 percent in the initial fifth) and a fair amount in the ending stages (19 percent in the final fifth); that he is little interested in planning action early in therapy and that about 5 percent of his conversation in the final sessions is devoted to planning. The client's attitudes toward himself and toward others tend to shift from negative to positive, a movement that is accentuated when current attitudes alone are examined. Considering current feelings, in the first and final quintiles, there is a shift from 31 to 62 percent positive and from 69 to 38 percent negative (33). These quantitative summaries confirm previous clinical impressions as reported in Rogers's 1942 book on nondirective therapy (28).

Directions of Change

On the basis of clinical observations, Rogers has suggested several *directions* of change in the content of successful therapy sessions. Movement may be expected from symptom to self, from environment to self, from others to self, and from past to present. In successful therapy the person learns "that it is safe to leave the less dangerous consideration of his symptoms, of others, of the environment, and of the past, and to focus upon the discovery of 'me, here and now'" (29). Rogers's clinical findings in regard to direction of movement provide a neat collection of hypotheses that could readily be tested by quantitative analyses of protocols.

Because clients talk about themselves and evaluate experience and value others in terms of themselves, investigators have found the self to be a useful construct in their explorations of client-centered therapy and have therefore revived a term that has been out of favor in psychology for a number of years. Several studies, beginning with

the important work of Raimy (25), attempt to specify changes that occur in the self during the course of therapy. It has been demonstrated that during therapy negative attitudes toward the self decrease and positive attitudes emerge and that at the end of therapy positive feelings outweigh negative feelings. Attitudes of ambivalence toward the self, never very frequent, tend to rise until somewhat beyond the mid-point of therapy and then to decline slightly.

The shift toward a more positive view of self is clearly evident in successful cases and is absent or is less clearly seen in unsuccessful cases, more pronounced in currently held attitudes toward the self than in attitudes expressed as belonging to the past. These statements describe general trends, and one would expect individual variations in the pattern from case to case. An interesting finding is that the person who makes no apparent progress in therapy may retain either negative or positive attitudes toward the self with a consistency that supports the defensive character of these self-regarding attitudes.

When one says that a person gains in positive attitudes toward the self, what is specifically meant? Sheerer (34) has shown that acceptance of self increases during therapy. This means that the person has come to perceive himself as a worthy person who can incorporate life's experience without distortion and who can act comfortably on his own perceptions and his own standards, needing no longer to guide his life according to the expectations of others. Other data tend to support Sheerer's findings, which suggest that after successful therapy the person has a more objective attitude toward himself and feels himself to be more integrated, independent, spontaneous, and genuine.

Quantitative Index of Change

The Stephenson "Q" technique permits one to derive a quantitative index of the relationship between two variables reflecting attitudes or opinions held by a single individual. For instance, it is possible to obtain an index number that indicates the extent to which attitudes toward self that were held prior to therapy are simi-

lar to those held after therapy or a number that indicates the relationship between a person's concept of his self and his expressed ideal self. In essence the procedure involves the sorting of statements representing typical self-regarding attitudes with reference to some criterion, such as the extent to which a statement represents one's current view of himself, or of his ideal self, or of the way he thinks others regard him, and so on. A high correlation of self-ratings before and after therapy would suggest that little change has occurred; a low correlation between rating of self and rating of self ideal would indicate a wide discrepancy between the two. *

A number of such self-relevant indices are available for a single individual, called Mrs. Oak, who was the first client to enter therapy in an extensive research program now under way to evaluate the client-centered procedure. Comparisons of the obtained correlations permit the following statements about the influence of therapy on the self-perceptions of Mrs. Oak:

The self bears little resemblance to the wanted self at the outset of therapy ($r = .21$).

At the conclusion of therapy the perceived self bears much resemblance to the wanted self ($r = .69$).

This increased congruence holds steady throughout the follow-up period ($r = .71$).

The perceived self changes markedly from what it is at the outset of therapy ($r = .30$).

The self-ideal remains relatively consistent during and after therapy ($r = .75$).

The change in the perceived self is gradual and directional, bringing it increasingly into congruence with the self which was wanted before therapy.

The pretherapy self as remembered at the follow-up period is more discrepant from both the pretherapy ideal and the follow-up self than is the self as sorted at that time. Consistent with the above, a qualitative analysis of the remembered self indicates that it is perhaps justifiable to regard it as a less defensive picture of self than was obtained prior to therapy.

* For a more detailed description, see Rogers (29, p. 140n.).

Rogers (29) and Snygg and Combs (36) hold that progress in therapy is characterized by an "increased differentiation of the perceptual field," or by a process of learning in which the individual abandons gross and often inaccurate abstractions regarding his life circumstances for more specific and accurate formulations, with a consequent increase in the appropriateness of his behavior. It is not clear whether this change results from learning in the usual sense, that is, by having new experiences that are in some manner tension reducing, or whether the new, more clearly differentiated and more accurate perceptions emerge as a result of reduction of anxiety. Of course both processes may occur. One can draw illustrations of the process of increasing differentiation from case after case. A professional man says early in therapy, "The trouble with my wife is that she is completely immature; she's still just a child." Later he notes that she manages three children fairly well, that she does better by the family budget than he does, that other people seem to think she is capable, and so on, until the original sweeping charges of immaturity are replaced by what seem to be more accurate appraisals, offering a much sounder basis for behavior.

Locus of Evaluation

There is experimental evidence defining another dimension on which it is possible to indicate change during the course of successful client-centered therapy. The dimension is concerned with what has been termed the "locus of evaluation," which refers to the extent to which the person's "values and standards depend on the judgment and expectations of others, or are based on a reliance upon his own experience" (29, p. 156). An analysis of fifty-nine interviews with ten clients showed a shift in the "locus of evaluation" from others toward the self, the trend being accentuated in the five cases judged to be most successful. As one client (not a member of this experimental group) expressed it: "I'm getting the feeling that it's me who is calling the shots in my life, and not somebody else all the time."

The correlation between an index of shift of locus of evaluation from others to self and a rating of outcomes by counselors is .60. After analyzing the relationship between the dimension that he proposes and other measures of change in therapy, Raskin points out: ". . . the locus of evaluation concept operates in a consistent relationship with previously established criteria of therapeutic progress, such as self regarding attitudes, understanding and insight, maturity of behavior, and defensiveness" (quoted in 29).

DIAGNOSIS IN PSYCHOTHERAPY

Rogers's Position

With reference to the function of diagnosis in psychotherapy, Rogers has taken a position radically different from that prescribed by tradition and has precipitated controversy and provided critics with a favorite issue with which to do battle. It seems important to recognize that Rogers's position is maturely held, that rational considerations prompted him to take a new viewpoint, and that therapists of many persuasions may gain more from a receptive study of his position than from an outraged rejection of it. The issue may be defined simply. Following medical tradition, in which treatment is built upon diagnosis, some therapists maintain that psychological treatment must also proceed upon an identification of causes and a selection of therapeutic measures indicated by a diagnostic formulation. Rogers, on the other hand, maintains "that psychological diagnosis as usually understood is unnecessary for psychotherapy, and may actually be a detriment to the therapeutic process" (29). What are some of the reasons for his departure from tradition on this issue?

Points of Departure

First it should be noted that most therapists recognize that psychological treatment is different from medical treatment in

that there can be no clear line of demarcation between diagnosis and therapy. The process of diagnosis will affect the client, favorably, one would hope, but possibly unfavorably, and the process of therapy will presumably affect the diagnostic formulation. Basically, what is involved is an ongoing relationship between two people; the designation of certain aspects of the relationship as "diagnostic" and of other aspects as "therapeutic" is arbitrary at best. Recognition of this relationship leads quickly to the question of what good or what harm can come from the procedures that are traditionally designated as diagnostic.

Rogers maintains that little good can accrue to the client from the fact that the therapist has arrived at a formulation of his problems because it is the client who must arrive at this formulation and experience its meaningfulness in his own terms. The issue rests largely upon who is to do the diagnosing. Rogers thinks that the client must do it:

Therapy is basically the experiencing of the inadequacies in old ways of perceiving, the experiencing of new and more accurate perceptions, and the recognition of significant relationships between perceptions The constructive forces which bring about altered perceptions . . . reside primarily in the client and probably cannot come from the outside. (29)

The therapist cannot speed the process by a prior discernment of the problem. To do so may make the therapist feel good, but it cannot make the client feel better.

Rogers also maintains that the client may be harmed if the therapist attempts to follow the diagnostic-treatment pattern. To Rogers, the attitudes that go along with diagnosis by the therapist (as opposed to diagnosis by the client) are incompatible with attitudes that are essential to a constructive therapeutic relationship. The therapist becomes the evaluator of initial status, of progress, and of final outcome, thus assuming a responsibility that should be left with the client if the goal of therapy is to promote maturity and self-responsibility.

Rogers does not accept the notion, which might be used to counter this position, that some abrogation of responsibility, some initial fostering of dependency, is necessary for therapy; indeed, he would argue that such a stratagem only prolongs therapy by postponing for the client the problem of learning to be responsible for himself. And Rogers contends further that the therapist has too much to do in simply understanding what it is that the client is trying to work through to be simultaneously formulating queries designed to aid in arriving at a diagnosis.

Additional Considerations

There are some other considerations less fundamental than those stated above. Psychological diagnosis is not highly reliable and provides a most tenuous and uncertain basis for the kinds of judgments made by therapists with a diagnostic orientation. One suspects that the relevance of these judgments to therapy is illusory, since antithetical judgments often seem equally beneficent in therapy, suggesting the operation of a third factor that has nothing to do with the precision of the diagnosis or the relevance of the judgment. Further, there is no evidence that we have therapeutic techniques appropriate to the differential diagnoses, except for gross differentiations required for interventional therapies, which involve shock, drugs, or surgery. And even here there is much to be desired with respect to precision. It seems likely that therapists contribute more to the variations in techniques than do the clients with whom they work. Therapists tend to carry on the kind of therapy they are accustomed to with all clients.

A strong emphasis on diagnosis has other implications germane to this discussion. In case conferences there is often a preoccupation with diagnosis; conjecture about etiology and psychodynamics offers a free-wheeling situation that can be, and often is, enjoyed as a kind of intellectual parlor game. In this game the prestige of the advocate of a point of view is likely to carry greater weight than his perspicacity, and the issues are likely to seem settled when he has made his

pronouncement, although no one has addressed himself to the question of how the diagnosis is supposed to help the client. But these arguments are not unanswerable. Someday we may have more reliable psychological diagnoses; we may be able to relate diagnosis to therapy, and we may learn to keep the good of the client central in our discussions of therapeutic relationships.

APPLICABILITY OF CLIENT-CENTERED THERAPY

Closely related to the problem of diagnosis is the problem of identifying the people for whom client-centered therapy would be most helpful. Probably because of the uncertainties in psychological diagnosis, the question remains unanswered in a fashion that we may hope someday to see. Rogers's current position may be summed up about as follows: There are no established contraindications to the application of the client-centered approach, and, in the hands of a trained person, there is nothing to suggest that harm may be done to an individual, regardless of his psychological status, that the relationship established in a client-centered therapy is the kind of relationship likely to be experienced as sustaining and liberating not only in psychotherapy but in other life relationships as well, that the only way to answer the question of whether a specific individual can profit from client-centered therapy is to give him an opportunity to work with an experienced therapist.

In the first book to present client-centered therapy (28, pp. 76-77) eight criteria for counseling were given. These required that the prospective client be under tension, that he have some capacity to cope with the circumstances of his life, that he have an opportunity to work regularly with a counselor, that he be able to express his conflicts verbally or through other media, that he be "reasonably independent . . . of close family control," that he be "reasonably free from excessive instabilities, particularly of an organic nature," that he be dull-normal or above in intelligence, and that he be of suitable age—"roughly from ten to sixty."

Today Rogers feels that these criteria are of little value. For one thing, they induce a diagnostic orientation not helpful in therapy, as described above. Further, the validity of some of the restrictions has been disproved by subsequent clinical experience. Apparently client-centered therapy has been effective with a wide range of people and problems: from two-year-olds to adults of sixty-five; from adequately functioning individuals to neurotics and psychotics; with people of all classes and of wide ranges in intelligence; with people who are physically healthy and people who are physically ill.

Further clinical experience and research should give us better understanding of the relationship between personality structure and ability to respond to client-centered treatment. The concept of individual differences, confirmed time and again in psychological observations, may certainly be counted on to operate with reference to the appropriateness of client-centered therapy for various people. From accumulated experience, one thing is clear: like other therapies, client-centered therapy helps some people a great deal, others somewhat, and still others not at all.

The problem is to identify the factors that are related to differential responsiveness to various kinds of therapy. There is some evidence that intrapunitive males respond well to the client-centered experience (14) and that aggressively dependent people are difficult to work with from this orientation. But data are meager and the broad problem hardly touched at present. One fairly plausible conclusion is that the dimensions of personality that are finally found to be significantly related to responsiveness to different types of therapy will probably bear only slight relationship to conventional nosological groupings. The most profitable research in this field in the near future will probably not be directed toward such questions as Will client-centered therapy work with psychotics? but toward an identification of the variables that operate in therapeutic situations and a relating of those variables to some broader theory of how people learn.

TRANSFERENCE

In analytic therapies transference is the fulcrum used by the therapist to help the client understand and resolve crippling patterns of behavior. Some theorists hold that psychotherapy is impossible without transference and focus their therapeutic strategy around its use; yet Rogers maintains that transference is not essential for therapy and that the possibility of short-term psychotherapy rests on the development of a relationship not dominated by transference. Transference does occur in client-centered therapy, with mild expression in a majority of cases and with strong expression in a small minority of cases. However, it clearly does not have the important function that it serves in psychoanalysis.

Rogers feels that the difference in intensity and frequency of occurrence of transference phenomena in psychoanalysis and in client-centered therapy is a function of the way the therapist responds to a client's initial manifestation of transference. In psychoanalysis, according to Fenichel, the therapist interprets, attempting to reveal to the client the unconscious impulses motivating his distorting behavior. This leads planfully to an intense emotional relationship between the therapist and his client, involving considerable dependency, which sustains the client through painful explorations and which must ultimately be resolved. In client-centered therapy, the therapist responds to manifestations of transference just as he does to other expressions of feeling: "he endeavors to understand and accept" (29). If the client perceives little in the behavior of the therapist to confirm his projections, he gradually comes to recognize their source in himself and he gradually rectifies his perceptions of the therapist. Minimum dependency is involved, and the course of therapy is presumably speeded. It may be that in client-centered therapy the therapeutic counterpart of transference in psychoanalysis is the opportunity of gaining experience in being responsible for oneself.

Schonbar (32) has made a penetrating analysis of transference

in relation to client-centered therapy. Essentially she sees transference as a protective mechanism brought into play by the client when the therapy situation threatens to precipitate more anxiety than the client can handle. Such anxiety arises when the therapist interprets, or when his efforts at understanding miss their mark, or when he is subtly rejecting the client. The "perfect client-centered therapist" would generate little transference. However, anxiety leading to transference may arise from the client's efforts to explore himself, even when working with a therapist who is quite understanding and accepting. Theoretically, in a "perfect" therapeutic relationship, the client will move ahead in the process of self-exploration at an optimum rate. However, the pace set by the client is not always timed perfectly; he may occasionally overstep himself, moving into areas of unmanageable anxiety before he is ready. When this occurs, protective distortions may be expected to occur.

INSIGHT IN PSYCHOTHERAPY

Most therapeutic theories have relied heavily on insight as a primary effector of change in personality. The promotion of insight is widely accepted as a major goal in various kinds of learning situations and especially in the learning that occurs in therapy. In his 1942 book, Rogers has a chapter entitled "The Achievement of Insight" and in the tradition of most inquiries into psychotherapy devotes considerable attention to clarifying the role of self-understanding in the process of therapy. In his book of ten years later, this chapter title was dropped out, and insight is mentioned only incidentally here and there through the book. There is no explicit treatment of insight, nor is there developed an argument for its omission. One can only surmise that the concept has tended to drop out because it was not very useful.

Indication of Change

In view of the widespread acceptance of the "insight as change agent" theory, it may be helpful here to present an alternate hypothesis regarding the function of insight in therapy. The alternate hypothesis should perhaps not be identified with the mainstream of growing theory designated as client-centered, although it is compatible with this theory (indeed, its origins are in experiences gained in trying to do client-centered therapy) as well as with psychological learning theory in general.

The alternate hypothesis holds simply that insight is an epiphenomenon, not a cause of change in behavior but one of the possible (but not necessary) indicators that behavior changes have occurred. Direct efforts to promote self-understanding are singularly futile, for deep and comfortable understanding is a symptom of adjustment rather than a promoter of it. Thus, interpretations designed to encourage the development of insight are acceptable only after they are no longer needed.

It is difficult to shake off the notion that insight is the central process in psychotherapy because we are culturally conditioned to believe in it ("Know thyself," and so on) and because in psychotherapy changes in behavior often occur about the time that insights appear. Because of our belief in the efficacy of self-understanding, we are willing to assume that the temporal relationship between occurrence of insight and change in behavior is so regular that a causal relationship can be inferred, forgetting the many times that there is evidence of insight without evidence of ability to act on the insight, * and forgetting, too, that changes in behavior in psychotherapy are often observed with no evidence of insight either on the part of the client or on the part of the therapist.

* So enamoured are we of the postulate that insight changes behavior that we deny the insightfulness of an insight when it does not produce a change in behavior. "Insights" not followed by changes in behavior are "intellectual insights"; "insights" that happen to be observed prior to observation of behavior changes are "real" or "emotional insights." Thus, insight is dependent upon an effect of which it is presumed to be the cause.

Repression of Responses

A reasonable next question is this: If insight does not change behavior in therapy, what does? The writer's conception may be summarized as follows:

We do not come by our maladjustments, our neuroses, our psychoses because of lack of understanding. We learn them through a sequence of concrete experiences that are hurtful to us, experiences that start early in life and involve us and our relationships with a very few important life persons—mother, father, siblings, or substitutes for them. We understand all too well how it hurts not to be loved, to be denied comfort, to be whipped psychologically, to be deceived, to be doubted. The concrete experience hurt when it first happened, and it hurts so much now when recalled by image or by symbols that we do not permit the recall. Instead, we repress, evade, distort, and in so doing we perpetuate our difficulties with people.

Insight into all this cannot help. The efforts to promote insight can only change behavior by encouraging repression of responses not approved by the therapist, since the client does not want to lose the support of the one person who seems to be on his side. The therapeutic potential of further repression is clearly limited. The therapist can help, not by trying to promote understanding but by making available to his client learning experiences that are as concrete, as immediate, as compelling as the learning experience that initially started and then nourished his neurotic way of living. Psychotherapy is a most personal business. In it the act is more important than the idea; the personal symbol more important than the insightful formulation.

In all psychotherapies there are four kinds of learning situations that can offer the primary level of experience necessary for extinguishing old and neurotic responses and gaining new and healthy ways of behaving. One of these learning situations is the immediate experiencing of a healing intimacy with the therapist. Another is found in the opportunity of learning new responses to highly personal symbols—symbols that are associated with earlier unhappy and

hurtful interpersonal relationships and that must be divested of their anxiety-producing potential. A third such situation is a kind of concrete experiencing afforded by transference in psychoanalysis and by practice in self-responsibility in client-centered therapy. And a fourth is a learning opportunity that becomes available to the client after he has begun to make progress as a result of the three kinds of concrete learning experiences noted first; these new learnings alter his behavior toward persons currently important in his life, possibly setting off a chain reaction of constructive interpersonal relationships that is ultimately more significant in reshaping his life than the somewhat confined learnings of the therapy situation.

PLAY THERAPY

It is very instructive to study therapy with children. Play therapy provides us with therapy in "pure culture"; it gets us away from the confusion of mazes of words of adult therapy and gives us an opportunity to look at the therapeutic process with fresh perspective. Because children, still viable and reaching out, often respond so well to play therapy, we can observe changes in behavior in relatively short periods of time, and thus in sharper focus, as compared with the time required for therapy with adults. Furthermore, with children we frequently have the benefit of reports of out-of-therapy behavior from parents, teachers, and others interested in a child, which make it possible to correlate developments in therapy with alterations in behavior at home, at school, at play.

To be sure, there are disadvantages to studying play therapy as a prototype of all therapies. Chief among these is the difficulty that we, as adults, have in responding to and knowing the meaning of all of the play of the child—projective play that wells from deep within, given expression in a private symbolism, wide ranging, unfettered by the literalness of the adult mind, free from adult prejudice with regard to temporal sequences and the ordering of space. Possibly we do as well as we do in play therapy not because we really understand

what it is that the child is saying to us, but because, if we try hard and refrain from gross self-projections, the child gives us the benefit of the doubt, equating his perception of the world with reality and naturally assuming that our perceptions must be identical with his. Such an assumption would give him a feeling of being completely understood by this new kind of person, a really warm and accepting adult. Such perfect communication we never capture again. The pre-adolescent, notoriously difficult to work with, has made the painful discovery of his apartness; he has discovered that all people see the world differently and can but imperfectly share experience, and he has little confidence that words can bridge this void between him and others. The adult is perhaps a little better off, in that he recognizes his aloneness and makes an effort to communicate his private world. The adult in therapy and his therapist, however, are often handicapped by the assumption that their words have greater communication value than they actually possess. Therapy with adults is probably most effective when it provides experiences that approach in concreteness the kinds of experience that children have in therapy.

Limited in his ability to use words (and at the same time free from their tyranny), the child expresses himself through play and the usage of various materials. A playroom should be of comfortable size, the floor waterproofed, the wall readily repaintable, and the lights and windows screened. It should be equipped with things that the child can use to act out his conflicts and give vent to his feelings: dolls and doll families; paints and clay; blocks and other construction materials; aggressive toys, such as guns, rubber knives, tenpins; toys inviting regression, such as nursing bottles; a carriage, a sand box, a water trough, a stage. This list is suggestive, not complete. *

More important than equipment, which may vary in amount and quality without seriously limiting the imaginative child, is the therapist. The attitudes regarded as essential in working with adults are equally important in working with children. The therapist must be willing to let the child work out his problems in his own manner

* For details of playroom equipment, as well as a most satisfying account of the philosophy and technique of play therapy, see Axline (3).

and at his own pace confident that even a young child has greater impetus toward integration than he has toward disintegration. As the child enters the play situation, he is often on his guard and plays in a noncommitting fashion until he finds in the therapist a warmth and steady acceptance that frees him for an open expression of his problems.

There is an observable difference between the early guarded and polite play of a child and his later projective play. In his projective play a child may range quickly from point to point (a mound of sand is a castle, a graveyard, a baby, a house, a fort, a volcano); or he may work patiently and repetitively on a single theme (week after week he lines up two armies, identifies himself with one, and then loses the battle that follows). The therapist needs to do his best to understand what it is that the child is saying and to communicate that understanding to him. Somehow, in this new and sustaining relationship, the child uses the therapist to work out a new definition of his self and a new way of perceiving his world. It is not that the child solves specific problems (though solutions to bothersome issues are often reported by relieved parents) but that he becomes a more mature person, better able to solve problems of today and tomorrow.

Client-centered therapy is a very permissive therapy, one that stresses the right of the individual to know freedom, to escape from the proscriptions of others, so that he can learn to impose his own restraints. The child in therapy uses freedom to learn personal responsibility. He learns to define behavioral boundaries and to conform to them because he wants to and not because he fears punishment or loss of love. In play therapy the child finds a tremendous freedom; he is freed from many of the prohibitions that strap him down at home or that confuse him because they are whimsically enforced. The child uses this freedom to express feelings that he must repress at home (the little sister whom he must "love or else" can be both loved and hated in therapy) and clears the atmosphere for growth.

At the same time that he knows the heady experience of free-

dom, the freedom to act as he really feels, he finds that there are a few sensible and secure boundaries that keep him from losing his bearings. The therapist establishes a few reasonable "limits"; for example, the child cannot take materials from the playroom; he must leave promptly when the hour is up. The child often uses these limits first to express his neurotic need to defy all limitations and then to demonstrate to the therapist and to himself that he can conform to the limitations because he wants to. * It is interesting to note how a child quickly discovers one of the few things that he cannot do in the playroom, how he tests the security of this boundary as though afraid that he will be successful in destroying it, and how he gets satisfaction later from controlling his own behavior with the limitation in mind ("How much time do I have left? I've got to put these things away before I go.").

Qualitative Considerations

Frederick Allen sees in play therapy an opportunity for the child and his mother to move forward in achieving psychological differentiation, a process started at birth with biological differentiation and completed only when the child has broken away from his mother and come back to her in a more mature relationship of adult to adult. The child and his mother come to the clinic together; they go their separate ways each with his own counselor; and they come back together again to return home. In this situation the mother realizes, often for the first time, that her child has a right to an existence separate from her. The practical question arises of whether it is possible to work with a child if his mother will not also enter therapy. Most people seem to believe that it is preferable to work with both mother and child (and sometimes with the father if he is available) but that it is still worth while to work with a child alone if his parents will not also seek assistance. A child may be the pivotal

* The same usage of freedom with boundaries is evident—though not so clearly—in therapy with adults. Perhaps it most frequently occurs in the client seeking to overstay his time not so much out of need to explore an issue as out of an infantile need to topple another rule, to deny realities of social living.

person in the reorganization that will permit him to draw the good from his family relationships instead of being warped by the bad.

Research in play therapy is still in the elementary stage. We have a number of clinical studies that report the results of experiences with one child and with a few children and present generalizations expressing the therapist's clinical appraisal of what had occurred. This is, of course, a necessary first step leading to quantitative studies, of which today there are only a few. The most important studies of therapy are those which illuminate the process (for the time being we can accept clinical impressions that something happens in play therapy and later turn to such questions as, What kinds of therapies are most successful?), but so far we have little illumination.

Landisberg and Snyder (18) used categories derived from analyses of protocols of therapy with adults to study records of therapy with four children. Reliability of judgments in the use of these categories was fair but not impressive. Detailed study of the therapists' responses showed that they generally followed nondirective procedures, though there was more interpretation (5 percent) than is usually found in records of nondirective therapy with adults. Physical activity on the part of the child increased during therapy, and there was a clear increase in the expression of feelings, most of the increase being accounted for by negative feelings. Positive feelings remained constant throughout therapy (at about 30 percent of client responses), and negative feelings started lower and rose to equal positive feelings.

In another investigation of the process of play therapy, which involved six children and six therapists, Finke (10) employed categories derived from play-therapy protocols—a procedure to be preferred to the use of categories developed for study of adult therapy—and achieved satisfactory, though modest, reliabilities and threw some light on trends in therapy. Stories made up by children increased up to the fifth contact and then declined; efforts to establish a relationship with the counselor came to a peak early, declined, and then rose again toward the end of therapy; testing of limits remained

evident until near the end of therapy; aggressive statements grew, fluctuated, and then declined; and the total number of statements rose until the third meeting and maintained a level until the end of the contacts. The above generalizations are based on averages of the performance of six children; considerable variability among the children suggests that they should be accepted with caution.

How effective is play therapy? Here again quantitative evidence is scarce, though clinical judgments afford abundant testimony to its effectiveness. Below is an excerpt from an investigation by Virginia Axline, a follow-up study in which children were interviewed several years after their therapy experience to find out what their retrospective perception of the experience was like. One child, aged fourteen when seen by the counselor and previously diagnosed as mentally retarded, could not come for an interview and wrote a letter instead. The letter is included here not only as an example of one kind of clinical evidence that is available but also as a moving, human document that conveys some of the spirit of play therapy:

Dear Friend:

I remember you because you were the first person who ever believed in me—who didn't think I was all bad—who didn't think I was silly—who took the time to try to find out how I felt about things. And you never dug into me like I was a person without feelings. You let me have my own world and my own way and did not try to snatch it away from me without first making me feel strong enough to go live in another world or to seek a new world or to go without a world for a while until I found a new one. It was as though you said to me you can hate and you can be sad and you can feel cheated by your mother because that was the way I felt. And so I didn't have to lie to you or feel ashamed because I was me. I painted pictures all the time because then I could think in peace. And the quietness was around both of us like a clean white shawl giving us warmth but not smothering. I washed myself clean in that silence. I crept back bit by bit into the world of color. It had been all black and grey before. I wasn't being sullen when I was quiet with you. I wasn't being hateful that day when I finally said I felt hate. I remember saying it deep inside myself, with the tips of my fingers scratching on the

slippery paper. This is hate I feel. It had been a numbness but it was not really numbness. It was not no-feeling. It was *hate* so big I was afraid of it. But that day I let the word creep outside of me that first time and it scared me. But it didn't scare you. I remember it because it struck me like a bolt of lightning. I am a hater, I thought. This is wicked and bad. Then they separated—the feelings and me. I thought you must *know* I have good reasons for my hate even though I hadn't told you then. Another time I mentioned my fear. It was then that I learned that a feeling was a changeable thing because I *felt* it change—in my heart, in my arms, in my head, in my legs. It came out and twisted and turned and lost its sharp edges. From that day on I was a free person because I could separate my feelings from the people I felt about. Then I began to look at myself and try and figure myself out. I got so I liked myself better. I got so I liked people. I got so I liked the world. I think this all happened to me because you gave me a chance to believe in *me*. And then I felt I was worthwhile. I have grown up since I saw you last. As I think back about it you didn't seem to do a thing but *be* there. And yet a harbor doesn't do anything either, except to stand there quietly with arms always outstretched waiting for the travellers to come home. I came home to myself through you.

Your friend,
Maryellen *

Quantitative Evidence

Let us turn now to quantitative evidence. Axline (3) and Fleming and Snyder (11) report studies in which play therapy is shown to influence scores on reading tests and on measures of general adjustment in expected directions. Both studies have flaws in design and must be considered as valuable but not definitive investigation.

Bills (5, 6) has carried out two studies that are neat in design and convincing in outcome. Using children of average to superior intelligence (mean I.Q. 123) who were retarded in reading and children who were members of a special class in reading, he administered equated forms of standardized reading tests on the following

* Axline, Virginia Mae, "Play Therapy Experiences as Described by Child Participants," *J. Consult. Psychol.*, 19:53-63, 1950.

schedule: six weeks prior to therapy, immediately before therapy, immediately following a six-week experience in individual and group therapy, and six weeks after the conclusion of therapy. Each child could thus be used as his own control to compare his gain on reading tests during a period of therapy with comparable periods of no therapy before and after. Significant gains in reading ability were registered during the therapy period as compared with the preceding control period, and these gains were maintained during the follow-up period.

The children participating in Bills's first study showed evidences of maladjustment. He repeated the study later with children for whom there was evidence of good adjustment and found no improvement in reading during the play-therapy period, a result that suggests that improvement in reading in the first study was mediated by improvement in general adjustment.

We still have much to learn about play therapy. It may be that studies of play therapy will provide a meeting point for workers with varying philosophies and that research at this point of merging procedures will throw more light on psychotherapy than will studies of disparate procedures followed in therapy with adults.

GROUP THERAPY

Basic Concepts

The basic concepts of client-centered therapy, developed first in working with individuals, have been extended to work with groups, with some modification, of course, and with sufficiently satisfactory results to warrant the conclusion that these basic conceptions have wide validity, ascribable not to the peculiarities of a specific kind of situation but to stable characteristics of people that are manifested in different kinds of situations. Research in group therapy has provided an independent check on hypotheses originating in individual therapy, thus increasing the degree of confidence with which one can accept these hypotheses as partly confirmed.

At the outset it is probably important to note that group therapy is not a second-choice therapeutic procedure advocated for economy reasons. With growing experience, we have realized that group therapy has unique potentialities and that it may often offer more therapeutic advantages than individual therapy. We do not know yet what the indicators are for individual or group therapy, but it is likely that some persons—or the individual at different phases of development—can work through their problems most successfully in a group. Group therapy may prove to be the “therapy of choice” for some individuals.

General Procedure

Some details of procedure in group therapy will set the stage for the discussion of theory and summary of research that follow. Groups are normally composed of about six clients and the therapist. So far there is no evidence to support assumptions about selection of participants; our practice has been to observe rough age groupings (children, adolescents, adults) and to have separate groups for psychotics. Occasionally special-interest groups, such as married couples, may be formed. The groups meet twice a week in a comfortable room for periods of 50 minutes to 1 hour. An effort is made to obtain electrical recordings of sessions. Observers are not permitted to sit in with the group, and the membership of the group is not changed after initial sessions.

Prior to the first meeting, the therapist has an interview with each prospective member to learn something of his problem, to describe for him the operation of groups, and to give him an opportunity to decide whether or not he wants to join a group. These initial interviews also help the therapist and the prospective group members to establish mutual feelings of security. The observations reported in this section are based on experience with groups of university students, soldiers, veterans with anxiety reactions and with physical complaints, clinical-psychology trainees, expectant mothers, mothers of problem children, delinquent boys, children, persons

interested in altering their attitudes toward members of other racial or religious groups, and others. Most of the people were relatively normal; some were neurotic, some psychotic. Most groups met for fifteen to thirty sessions.

Role of the Therapist

In studying group therapy, we again find that the attitudes and skills of the therapist are all important. It is possible for groups to become "bull sessions" or intellectual forums; the therapist is the catalyst that turns this coming together of people into a therapeutic experience. The phrases used to describe the behavior of the leader can become worn, but the experiences for which they stand remain vital to the people involved. The therapist must first of all be thoroughly accepting of others, not because he thinks he should be accepting but because that is the kind of person he is. He should be sensitive to the feelings of others and able to communicate his understandings to them. He must be free from urges to have the group move in a specific direction because of his needs, and he must have confidence that the group, and the individuals in the group, can find their own best directions.

There is an important distinction between group therapy and individual therapy in a group, and it is largely the behavior of the group therapist that determines which of these patterns will emerge in a given group. The skilled therapist seeks to bring into action the therapeutic influence of the group itself. His task is a demanding one, requiring considerable social sensitivity. In the beginning he must carry almost all of the responsibility for therapy; yet he must be willing to share this responsibility and ready at the first appearance of therapeutic interaction in the group to withdraw for a while and let others take over. And he must remain ready to contribute when important feelings are not picked up or when conflict among group members threatens.

Evidence suggests that there is an optimum level of participation by the therapist. Telschow devised a measure of discord in

groups and found that, in three groups, the group in which the therapist participated least developed most discord, whereas the group in which the therapist participated most (though still not much as compared with the amount of participation expected of therapists with other orientations) developed least discord. The effective group therapist is one who succeeds in maintaining a minimum level of anxiety in a group while encouraging members to take over the role of therapist. He thus multiplies therapy by an imponderable but crucial factor and achieves true *group* therapy.

In a painstaking and insightful analysis of the role of the therapist in a group, Telschow (38) also demonstrated that simple acceptance of what is said, along with restatement of content and clarification of feeling, promotes self-exploration on the part of group members presumably by reducing the amount of threat involved in the hazardous business of self-scrutiny. The therapist tends to interact most frequently with the most active members of the group, as would be expected. The members of the group who gain most, however, are those to whom the therapist is able to respond in a nondirective manner.* This does not mean that the therapist role is a passive one. On the contrary, the therapist must maintain an active interchange with group members; if he does not, discord mounts and therapy slows down.

The amount of activity of therapists tends to fluctuate from session to session, but there is no tendency to diminish as therapy progresses, which would be a reasonable expectation. Fluctuation in the activity of the therapist may be a function of extraneous considerations, such as the weather or the state of his health. We like to think, however, that the fluctuations represent a sensitive modulation of the therapist's responses to the requirements of the group at any moment. The data do not tell us which it is. It seems clear that a group member's perception of the statements of the therapist is crucial. Members of groups who responded most frequently in a

* The correlation between member and therapist activity provides an index of the degree to which therapy is "group centered." For the groups studied, a correlation of .86 between these variables was obtained.

defensive manner to statements by the therapist were members who gained least from the group experience. The important thing seems to be that the group member feel that he is in a situation free from threat where it is safe to examine himself openly.

From Harry Stack Sullivan we learn the importance of seeing the individual in relationship with other individuals, including his relationship with the observer. In growing up, each individual defines and redefines his self in relation to important life persons, a process that speeds along in early life and changes in acceleration at different periods of life, now fast and now slow, but never ceases until death puts a stop to it. It seems likely that important changes in personality can be worked out only in meaningful relationships with other people. Individual therapy provides such an opportunity; the relationship of therapist and client is the alembic in which new ways of perceiving self are distilled. The genius of group therapy may lie in this: that it provides not a single interpersonal relationship but a matrix of interpersonal relationships that an individual can use, and contribute to, in the process of redefinition of self. One of the fascinating phenomena of group therapy is the evident contribution that members make to each other in their shared striving for more satisfying ways of living. Gorlow (13) has studied in a very creative fashion the behavior of group members when they take the role of therapist.

Content: Progression and Change

Topical themes thread their way through a series of group sessions, giving expression to the concerns of the members. One member may initiate a theme and work toward a solution of the problems involved. A second member may be caught up in the process because the problem is his problem too. A third member may feel more secure in the area in which the other two are struggling and enter the discussion in the role of therapist. As the sessions progress and new themes are introduced and old ones re-examined, individuals shift their roles, acting sometimes as clients and sometimes as

therapists. There is evidence that members become better able to take the role of therapist; from initial to final sessions there is an increase in permissive and accepting behavior and a decrease in critical, evaluative, and interpretive behavior.

This shift in role from that of client to that of therapist can be accounted for as follows: The members may simply learn, by imitating the leader, to use nondirective responses; or they may gain in self-acceptance and personal comfort and, as a consequence, tend to adopt more accepting attitudes toward others; or both factors may be involved. Gorlow's data show that those individuals who are best adjusted before therapy are the ones who most readily adopt the role of the understanding and noncritical helper of others in initial sessions. In later sessions, these early differences gradually disappear, presumably as a result of the influence of therapy. However, group members whose Rorschach records show most anxiety and hostility before therapy continue to be critical, evaluative, and disapproving to a greater extent than members who are initially less anxious and hostile. Regardless of how we account for these relationships, it is clear that group members become more adept in responding to feelings and in aiding others in their self-explorations. Furthermore, members who gain most from the sessions are those who most often use responses that are considered most therapeutic.

To a group therapist witnessing the emergence in an individual of concern for others is a thrilling experience. In early meetings of a group, each member often seems encapsulated in his own problems, unable to devote sustained attention to problems of others, interacting with other members only in a desultory fashion or occasionally with such intensity that it is clear that a problem stated by another has come close to home and thus requires defensive measures. Gradually individuals gain in freedom of movement as their anxieties are lessened and then reach out to help others with their anxieties. Often a group member will demonstrate deep understanding of another and be able to respond with a sensitivity surpassing that of the therapist. To such multiplying of therapists may be ascribed some of the unique therapeutic potential of group therapy.

The opportunity for a person to express his concern for another person and to be in part responsible for helping that person work through his problems may be one of those concrete experiences that stimulate growth in the direction of maturity. Certainly one of our most exacting criteria of maturity is the ability to be constructively concerned with the welfare of others. Practice in helping others while receiving help is an experience available in group therapy but not possible directly in individual therapy.

First expectations are that it will be quite difficult to talk about one's intimate problems in a group. The prospect of participating in a therapeutic group brings to mind other groups, social and educational, in which one had constantly to be on guard lest he tip his hand and open himself to rejection or attack. Here the therapist makes a difference. Members of a therapy group gradually find that this group is somehow different. Usually one person out of the six, either more confident or more driven by his need for help, will start talking. Others observe that his ideas and feelings are accepted in a manner that makes it easy to go on, and they take courage. Or others may find in his statement reflections of their own problems and gradually become involved in the therapeutic process through identification with him. It may actually be easier to talk in group therapy than in individual therapy.

The sharing of responsibility for the course of an hour may also reduce pressure and make self-exploration easier. A good hypothesis is that the rate of self-exploration will be inversely related to the amount of perceived threat in the situation. Therapy should go better if the individual has an open avenue for easy retreat when the demands of self-exploration are too great. Direct retreat is often impossible in individual therapy; various techniques of "resistance" have to be employed to talk out the hour without getting hurt. In group therapy direct retreat is easily possible; the person can simply be quiet. There is minimum pressure to participate, and the person can regulate his speed of exploration, moving forward at an optimum pace.

Hoch (16) has provided insights into the process of therapy as

revealed in an analysis of the protocols of some sixty group sessions. His approach to the problem is comparable to the studies of the process of individual therapy already reported. If expression of aggression and hostility is a measure of involvement in therapy, then it seems that groups take a little longer to warm up than does a person in individual therapy. Expressions of hostility are low in the initial sessions, rising to a peak after a few sessions and then gradually declining. Expressed positive feelings grow throughout the sessions in a manner comparable to their pattern in individual therapy. Ambivalent feelings toward the self remain infrequent.

In contrast to findings in individual therapy, in which there is a gradual decline in presentation of problems, problem-stating behavior continues throughout the group-therapy sessions. Therapy appears to be not so much a problem-solving activity as a process in which the individual becomes better able to solve problems, which continue to come up. The process is not a static one. Progression from session to session is evident in the changing quality of behavior of the group members. Expressions of insight, of positive planning, of positive attitudes toward the self and toward others increase and are significantly more in evidence in the second half of a series of sessions than in the first half. This trend toward more healthy attitudes is notably evident in the statements of group members who gain most from the experience. It is also interesting to note that the members who gain most tend to avoid intellectualizations, to stick to their own concrete, personal experiences, and to become able gradually to show concern for others in the group.

Is there any justification for talking about group therapy as though it were an identifiable process that could be repeated from group to group? Hoch presents evidence of the comparability of behavior of therapists and members of three different groups, indicating a marked similarity in what goes on. Though different individuals are involved and the stated problems are quite diverse, there is much overlapping in the kind of experience available to each member. By putting each statement into a category designating its feeling and import, it is possible to correlate frequencies of occurrence of various kinds of

statements. When this was done for three groups, the resulting rank order correlations were .84, .86, and .87. When the same comparisons were made among individuals, a wider range of correlations was obtained, the coefficients varying from .46 to .97. These correlations in total suggest a decided similarity of climate from group to group with ample evidence of individual variability.

Just how effective is group therapy? The question is as difficult to answer with precision for this approach to working with people as it is for individual therapy. There is abundant testimonial evidence of its effectiveness. There are reports of behavioral changes by participants and by observers of participants. Then, there is the judgment of clinicians who work with groups and also with individuals. Finally, there is some quantitative data: of eighteen participants in three groups, nine showed clear gain and nine showed no gain or uncertain gain, as judged by three clinicians and confirmed by objective tests. There is enough evidence of favorable outcomes of group therapy to warrant its use and to encourage further research.

EFFECTIVENESS OF CLIENT-CENTERED THERAPY

To assess the effectiveness of any kind of psychotherapy is exceedingly difficult, and what evidence can be gathered concerning the effectiveness of client-centered therapy leaves much to be desired. However, there has been a consistent effort by this group of workers to subject their procedures to objective and quantitative study, and the results of published investigations, though often sketchy and inconclusive, at least demonstrate that therapy can be studied as other social phenomena are. In time, one may confidently expect this insistence on objective inquiry to prove worth while. Already more comprehensive studies are under way.

At the time that Rogers's *Client-Centered Therapy* appeared (1951), there were available the results of several studies that involved 123 clients, thirty therapists, and four clinics and were directed toward determining what changes, if any, occur in the

structure of personality as a result of participating in client-centered therapy.*

Muench (21) gave twelve clients the Rorschach, the Bell Adjustment Inventory, and the Kent-Rosanoff Word Association tests before and after therapy. Using signs of adjustment on the Rorschach, he found significant changes in the direction of better adjustment, the changes being greatest in those cases judged by the therapist to have been most successful. Comparable changes toward better adjustment were revealed by the two more objective tests as well. Muench's study, weak in that it did not permit comparison with a control group, was bolstered by a study by Hamlin and Albee (15), who demonstrated that a comparable group of subjects who were not receiving therapy showed no significant changes in Rorschach pattern. Results contradictory to Muench's findings in so far as Rorschach results are concerned are reported by Carr (6), who used essentially the same analysis with nine cases. He found no significant changes in Rorschach adjustment indices. However, Mosak (cited by Rogers, 29) confirmed Muench's findings with regard to changes on the Bell Adjustment Inventory. The mean scores of twenty-eight clients dropped from 62.8 to 47.6, a statistically significant change. Improvement was shown on all five areas measured by the inventory.

Haimowitz (14) gave pre- and post-therapy Rorschachs to a group of fifty-six clients in individual or group therapy and to fifteen persons in a control group. Employing a method of analysis developed by Harrower-Erickson, Haimowitz found a statistically significant drop in the number of neurotic signs and a significant rise in ratings on characteristics denoting improved adjustment. In the control group, the number of neurotic signs remained unchanged, and there was no improvement in ratings of adjustment. Haimowitz followed up ten of the persons in the experimental group and gave them the Rorschach one year after termination of therapy. These ten subjects continued to hold the significant gains that they had made in

* For a more detailed discussion of outcomes of client-centered therapy, see Rogers (29), pp. 172-186, from which these materials are drawn.

therapy (with some slight, but statistically not significant, gain) during the follow-up period. Scrutiny of scores of individuals reveals that the gain of the group could be accounted for by the gains of six members; four of the members either made no gain or regressed. The Haimowitz study also yielded one tentative finding of importance with reference to the kind of person likely to respond to client-centered therapy: he found that neurotic and strongly intrapunitive males responded with the greatest degree of personality change.

Other studies using objective inventories give evidence of changes in personality as a result of client-centered therapy. Using the Minnesota Multiphasic, Mosak found significant movement toward better adjustment on five of the nine diagnostic scales for his twenty-eight subjects. For the group as a whole before and after therapy, there was a general lowering of the profile, which suggests a pervasive rather than a specific pattern of change, though it is possible that individuals within the group could make changes in a few areas and not in others. The Hildreth Feeling-Attitude Scale, a self-rating instrument, and the Bernreuter have both yielded evidence of change during therapy in the direction of better adjustment. The improved Bernreuter scores remained steady twenty months after the conclusion of therapy (7).

There are several other important researches that get at the crucial question of whether or not a client's *behavior* changes as a result of client-centered therapy. It has been demonstrated in three studies (33, 35, 37) that toward the latter part of therapy clients verbalize plans to change behavior and report ways in which their behavior has already changed. These statements may need to be discounted somewhat as being good intentions only, but they should not be omitted from the picture. A step removed from planning is the client's report of his current outside behavior. In successful therapy cases, reported outside behavior increases in maturity, as appraised by a judge working only with statements extracted from interviews (17). The Dollard and Mowrer Discomfort-Relief ratio, indicative of expressed psychological tension, decreases during therapy and falls most sharply in cases that were judged successful on other grounds

(30). Defensive behavior tends to diminish and insight into remaining defensiveness increases; these trends are apparent not only in outside behavior as reported but also in behavior exhibited in the interviews.

There is additional evidence of a different sort: frustration tolerance, as indicated by physiological measures of recovery from stress, has been found to be greater in a group that had received therapy than in a control group that had not (39). Job supervisors, without knowledge of the progress of counseling, rated 393 veterans who were receiving personal counseling as follows: 17 percent showed no improvement; 42 percent showed some improvement; and 41 percent showed much improvement. In general, the study showed that as the number of counseling interviews increased, the frequency of reported improvement also increased (29, p. 185).

In total the evidence strikes the writer as showing unequivocally that something happens to people when they participate in client-centered therapy and that it happens in directions generally considered to be desirable. There are those who now call for a demonstration of the relative effectiveness of different kinds of therapy. It was perhaps necessary to confirm by objective studies the clinical observation of change in client-centered therapy, but it would seem singularly unrewarding at this stage to enter upon comparative studies of outcomes of therapies. Far more crucial are studies, either comparative in nature or devoted to examination of one orientation, designed to throw more light on the process of psychotherapy. Current descriptions of the process of therapy, written from any point of view, contain thousands of untested hypotheses that invite objective study.

PERSONALITY THEORY

The accumulation of clinical and research data has reached a stage at which there is both a demand for, and a possibility of, a client-centered theory of personality and behavior. Rogers has supplied an outline of this theory in the last chapter of his most recent

book. The theory is presented in nineteen propositions, with some elaboration of each, and the reader who is interested in a detailed development of the theory is referred to this primary source. To round out our presentation of client-centered therapy, there will be attempted here a summary of its theory.

The experiencing individual is the primary reference point in client-centered therapy. Complete understanding and acceptance of experience define the unattainable ideal of the client in his struggle for a more satisfying life and of the therapist in his efforts to help the client in this struggle. Understanding is often sought, but rarely is it attained completely: the client's efforts to understand his world are related to his own perceptual field. Thus, for the client, only a small portion of experience can be held in focus at a given time; a much larger portion of experience is available to awareness to meet needs of the moment; and a portion, varying in amount from person to person and within a person from time to time and from situation to situation, is not readily available to symbolization. This last portion appears to extend along a gradient of accessibility, some being accessible at most favorable moments, some accessible only as a result of a reorganization of personality, and some not accessible at all. Only a portion of what the client experiences can be known to the therapist; the ineluctable apartness of people imposes its barriers to understanding.

The reality with which both client and counselor are concerned in therapy is reality as perceived by the client, whose behavior is determined by his perceptions of himself and of his world. For most individuals there is sufficient correlation between "objective reality" and "reality as perceived" to permit effective behavior. The correlation is low on occasions, as when one walks into a closed door believed to be open; or it is low for a while, as when one is infatuated by love; or it is low continuously, as when one is psychotic. For two people, such as the therapist and the client, who are trying to communicate, there is usually sufficient community of experience and sufficient overlapping of perceptual fields to make possible a meaningful interchange of ideas and feelings.

The reality with which client and counselor deal is the perceived reality of the present. Past and future have relevance only as they are conceptualized as current data with which the client is working or as tension systems that influence present behavior without clear symbolization. There is nothing unusual about this idea, except that emphasis upon it leads to different operations in therapy. The historical past and the projected future are useful conventions in which the behavior of groups of people needs to be coordinated, and some therapists treat them as though they have validity independent of the person with whom they are working—the “past” is probed and the “future” predicted. By contrast, client-centered therapy is a therapy of here and now.

The individual reacts as an organized whole to his perceptual field, and all elements of the process are in dynamic relationship with one another. Thus, changes in one area can be expected to influence the total configuration, with consequent over-all changes in behavior. Simple “habit” explanations of behavior appear to be inadequate to account for observed events. For example, in play therapy, a child may paint on the walls and flood the floor with water; instead of adding these “habits” to his repertoire of misbehavior at home, he seems now to have less need to misbehave in general. Behavior is not a matter of making specific responses to satisfy specific needs; a more fundamental kind of motivation is involved.

Rogers maintains (together with others not identified with client-centered therapy) that the basic motivation of all organisms is to maintain organization against threatening experience and to enhance organization in required directions. The requiredness arises not from the operation of some entelechy (as has been charged of client-centered theory) but from the nature of the organism itself. Female chicks grow up to be hens; one would be astonished if they turned out to be ducks, dodos, or dinosaurs. A wounded finger of a healthy man heals itself, or a staphylococcus is true to its own nature and kills the man. A child grows into a man, realizing his own peculiar physical organization until death, at which time other equally valid kinds of organizations continue in their required directions. It

seems that Rogers is simply saying (along with others) that this principle applies to the whole of man and not simply to his physical being. The behavior of the organism is goal-directed, but needs and goals are both part of the immediate present. Behavior is not caused by past events nor is it shaped by goals that transcend the present. When we speak of "future" goals, we are using a convenient classification for present experience.

It is in conjunction with goal-directed behavior that emotion comes into play. Rogers subscribes to the analysis of emotion formulated by Leeper (20) which holds that emotions experienced as unpleasant or exciting accompany goal-seeking efforts and that emotions experienced as calm or satisfying occur at the consummation of the experience. The intensity of emotion is a function of the extent to which organization is threatened.

The organization that the individual strives to maintain is not physical but conceptual. The child is born with a growing ability to perceive events occurring in his world. Gradually he acquires the ability to attach symbols to these events and gains thereby a tremendous tool for controlling events and for communicating with others about them. Events of the child's world are not all of a kind; some events are perceived as having much greater significance for his organism than others. In early life, frequency and intensity are involved in determining this significance (the child's hand appears with greater frequency, and greater dependability, than the sides of his crib; eating and eliminating have an organic intensity greater than playing with a toy).

As the child grows older, verbal symbols become increasingly important in his daily life and gradually become more potent even than food and pain and comfort in determining behavior ("Jack is a good boy"; "Bill is not loved"; "Jane is very pretty and kind"; "John is a good soldier and doesn't seem to know what fear means"). Gradually out of the total perceptual field there is differentiated a class of events and of symbols which we designate the self. The differentiation is not sharp; it is better to think of a gradient from self to not-self. It is this organization of self that the individual seeks to preserve

in situations perceived as threatening to its organization and to enhance in situations perceived as sustaining.

In writing about the self, the word "perceived" has frequently to be employed. The self and the world as experienced seem so central to the process of therapy that client-centered theory has gradually evolved as a phenomenological theory. A phenomenological theory seems to provide a level of description appropriate to the kind of data we now have and to permit better prediction of behavior in therapy.

The self is defined largely in terms of interaction with other people. The greatest amount of the variance in the self is accounted for by one's relationships with a relatively few important life persons—mother, father, siblings, mate, possibly one or two others—and the remaining small percentage of the thousands of persons with whom one has passing relationships. These self-defining interpersonal relationships are loaded with value judgments. And it is in the origins of value judgments that Rogers finds the origins of later adjustment difficulties. Rogers feels that some values have an organic validity for an individual. The child perceives the love and approval of his parents and knows that it is good. He responds positively, and there is harmony among symbols and organic reactions.

However, the child has some organic feelings which he learns are not acceptable to his parents. His feelings tell him that he loves his little sister and that he hates her too. But his parents tell him that he must love his sister 100 percent, all the time. Because the child does not dare risk losing the love of his parents, he comes to accept this value judgment *as though* it were his own. To act on this judgment, he must now deny or distort the organic sensations of hate that continue to occur. With a hundredfold multiplication of this process, the individual grows to the point where he feels, "I really don't know myself"—an expression frequently heard in psychotherapy. The healthy individual is one who can incorporate without distortion most of the data of his living, and among the most significant of these data are his organic reactions to experience.

An individual does not passively respond to all available stimuli.

He goes forth to meet his world, and he responds selectively to what it offers. It is the organization of the self at a given moment that determines what will be responded to and how it will be handled. Events that have no perceivable relationship to the self are ignored; events that are perceived as having significance for the self and are compatible with the self-organization are symbolized and incorporated into the organization. Many writers have pointed out that living is a process of becoming more of what we already are.

Trouble comes, however, from a third and essential way of reacting to events. Some events are perceived as having significance for the self but as being incompatible with the organization of the self; these events are either actively denied or are distorted to a point of acceptability. The important thing here is not whether the event is favorable or unfavorable but whether it is consistent or inconsistent with the organization of the self at the moment. For example, father cannot accept reports of clinic after clinic that his son is mentally retarded; a college student with a picture of himself as being intellectually mediocre interprets his 135 Wechsler I.Q. as evidence that the test is invalid. There is clinical and experimental evidence that this process of coping with events not compatible with the self-structure can occur without the individual's being directly aware of the occurrence. The process may be manifested indirectly in anxiety.

The individual strives to behave in a manner compatible with his self-organization. Even when torn with conflict, he usually finds a way of dealing with conditions that maintains some self-consistency ("I hate this business of being a soldier, but while I'm at it I'll do my job well"). There are times when organic needs, the satisfaction of which is incompatible with self-organization, become so intense that they burst into overt expression.* Looking back on such events, the individual is likely to feel that they somehow do not belong to him ("I was not myself when I did that"; "I don't know why I do it—I don't want to do it, but yet I do").

* At the time of the act, the pressure of great organic need probably alters the person's perception of the situation to such an extent that its basic incompatibility with his long-term self-picture is not evident; the act is perceived as required at the moment only to become a source of remorse later on when its self-contradictory nature becomes apparent.

Let us return now to a statement previously made. A person achieves adjustment to the extent that he can, without distortion, admit to awareness and symbolize sensory experience arising from external or internal sources. This is the meaning of the much-used phrase "self-acceptance." The person's self-organization is such that he can symbolize accurately his ambivalences; he acts with all the data in. His behavior is not only likely to involve minimal discomfort to himself but to be perceived by others as spontaneous and appropriate to the situation. As Lecky has pointed out (19), the individual has a sense of control. When the individual perceives himself to be in a situation threatening to his self, the feeling of control is diminished, and the individual adopts emergency measures. Others now perceive his behavior as rigid and stereotyped. The catastrophic reaction to organic impairment, described by Goldstein (12), appears to have its counterpart in the neurotic's desperate rigidity in response to perceived threat to the self. The heightened rigidity in response to perceived threat only adds to the person's difficulties; events that formerly seemed innocuous may now be perceived as threatening. More and more distortion is necessary just to keep going.

One might well ask: What stops this frightening process? Why do we all not become psychotic? There is another aspect of the process that works in the opposite direction in an equally compelling fashion. When an individual perceives himself to be in a situation that is dependably sustaining of himself, the need to distort experience is decreased: he gains in freedom to explore denied areas of experience; he symbolizes experience more accurately; he gains increased control of his behavior. It seems likely that an individual can achieve this security for self-exploration only in intimate relationships with other people, a viewpoint consistent with our earlier observation that the self in childhood, in its formative stages, is worked out in relationship to other people. It is a common observation that many life relationships are therapeutic; they prompt expansions of the self that are enduring and deeply satisfying and often observable by others.

Psychotherapy is an attempt consciously to embody in the relationship of client and therapist those elements that reduce to a mini-

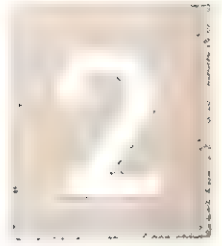
mum perceived threat to the self and raise to a maximum the sense of being sustained in the hazardous task of self-exploration. In such a situation, the individual comes to "accept himself," that is, he assimilates into his self-organization more and more of his experiences. He redefines his self in the relationship with the therapist. It is interesting and theoretically important to note that as he gains in acceptance of himself, he gains in the ability to accept others. Essentially this means that he no longer perceives others as agents of experiences likely to threaten his self-organization. He can accept them because he has already accepted himself. He has come to the point where he no longer relies on others for an evaluation of his experience; he measures his behavior by his own value structure, which is now rooted deeply in his organic reactions to experience.

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Hypnotherapy

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Hypnosis is one of the oldest of the medical arts and was practiced extensively by the ancients, who were convinced of the divine nature of the trance. Modern-day hypnosis, however, originated in the work of Franz Anton Mesmer, who, despite opposition by members of the medical profession, demonstrated the therapeutic value of this technique. It was Josef Breuer, however, who, in 1880, in his fascinating case of Anna O., discovered and recognized the real place and value of hypnosis as an adjunct to psychotherapy, changing the emphasis in hypnotic therapy from direct symptom removal to dealing with the apparent causes of symptoms.

Hypnosis has been used successfully in various types of psychotherapy—in directive therapy and suggestions, directed toward symptom removal, in nondirective therapy, in release therapy, in psychobiologic therapy, and in psychoanalysis. It has also been used with a wide variety of mental symptoms and illnesses, including anxiety neurosis, compulsion neurosis, traumatic neurosis, psychosomatic conditions, character disorders, alcoholism, and habit disturbances, and to a limited degree with psychosis. Wolberg believes that hypnosis can shorten the psychotherapeutic process, because, if properly applied, it can break through interpersonal defense and help to establish a closer relationship between the patient and the therapist. This method can also shorten the re-educational phase of treatment by permitting easier incorporation and absorption of wholesome interpersonal attitudes.

Hypnotherapy

FOR MANY CENTURIES hypnosis has been associated with charlatanry, and it is still colored by superstition and magic. To many persons it continues to be a decadent art; to others it is a source of magic or miracles. Unfortunately, these attitudes prevail not only among the laity but also among members of the medical profession. There are psychiatrists who believe that hypnosis is an antiquated and outmoded form of treatment to be classified with cupping and bloodletting; there are other psychiatrists who, frustrated by the great length of time required to treat neurotic problems or by their own therapeutic ineffectuality, have recourse to such dramatic procedures as narcosynthesis, shock therapy, and psychosurgery.

What are the true facts about hypnotherapy? Has it validity? Under what circumstances is it used most advantageously? When is it ineffectual or contraindicated? How may it be best employed? These and other questions are the concern of this chapter, which is intended as a general survey of the field of hypnotherapy.

Today there is sufficient information about hypnosis to indicate that it has many potentialities, provided that it is judiciously employed in the context of a psychotherapeutic plan. A legitimate question is this: What properties of hypnosis lend themselves to psychotherapeutic application?

In the main, the trance state influences the individual in two ways. First, it produces a remarkable relationship to the hypnotist, in which the subject accepts suggestions that enable him to experience widespread psychic and somatic effects. Second, it tends to modify or to remove repressions that keep certain aspects of the personality from awareness. The first property of hypnosis is probably

based on the fact that the trance symbolically represents to the patient a relationship with an idealized parental figure to whom he submits and whose suggestions he follows in the hope of winning love, support, and a variety of bounties. This type of relationship expedites certain authoritarian therapies, such as reassurance, guidance, persuasion, and symptom removal through prestige suggestion. The second property is based on the deadening effect that hypnosis has on repression, which permits the return to awareness of material that has been relegated to unconsciousness.

Yet, hypnosis by itself has no permanent psychotherapeutic influence. It is effective merely as a catalyst to the psychotherapeutic process; consequently, it must always be employed in conjunction with specific therapeutic techniques. This means that the therapist must not only know how to induce a hypnotic trance but must also have a solid grounding in psychotherapeutic theory and practice.

SYMPTOM REMOVAL THROUGH HYPNOTIC SUGGESTION

Prestige suggestion employed in the trance state constitutes the traditional use of hypnosis during the past centuries. This application has the advantage of speed and in susceptible subjects produces almost miraculous results. It also has many disadvantages. One of these is the very limited application, since few persons are actually susceptible to this approach. Another disadvantage is the evanescent character of the effect; symptoms usually return in the same or in somewhat altered form. Furthermore, it possesses the disadvantage of treating results rather than causes of an emotional problem. Nevertheless, one may have no choice but to use prestige suggestion when a more rational kind of therapy is not possible. Often a neurotic symptom may be so destructive or so incapacitating to the patient that it blocks psychotherapy; it may even constitute a source of danger to the individual. Here the only course may be the

use of suggestive symptom removal at the same time that the patient is motivated to accept deeper therapy.

The problems that yield best to symptom removal by hypnotic suggestion are those that have a minimum defensive or secondary gain value for the patient. Among the most responsive conditions are certain hysterical symptoms, such as tics, contractures, spasms, paralysis, sensory disturbances, aphonia, visual disorders, amnesia, somnambulism, and fugue states. Habit disorders may also be helped. These include excessive smoking, nail-biting, insomnia, and over-eating.

For example, hypnotic treatment was given a patient who had paralysis of one leg. The paralysis had grown progressively worse over a period of years, necessitating walking with a crutch. The symptom was obviously hysterical in nature and had resulted in his losing a valued position. Unable to support himself financially, he had relapsed into dependency on his relatives, who were openly resentful of their charge. Symptom removal was decided on when it became obvious that the patient had no desire for extensive psychotherapy. The total treatment consisted of one session and restored him to functioning so that he was able to regain his position, which he still has. There has not been a return of paralysis in several years.

By means of the induction method of hand levitation, which will be described later, the patient was put into a trance and then given suggestions. The first step was to paralyze the patient's arm. The purpose of this was to convince him that it was possible to have paralysis in another part of his body. Paralysis was then removed from his leg, and it was suggested that he visualize the two of us walking together, so that he would get a sensory impression of his capacity to ambulate. Next, he was regressed to the age of thirteen, an age at which he had walked freely, thus demonstrating that he was capable of walking. He was then returned to an adult level, and the performance was repeated. Following this, suggestions were made that he would be able to walk through his own efforts. Reinforcing suggestions to the effect that his paralysis would disappear

were then given him, and posthypnotic commands were directed to the same end.

The permanence of results in symptom removal has been questioned. In considering this type of therapy, we need to take into account that symptoms are actually by-products of the individual's collapse in life adaptation. They are merely manifestations of a destructive process akin to smoke that issues from a fire. We must recognize that the removal of a patient's symptoms may be as ineffectual as blowing smoke away when we actually should be extinguishing the fire that produces the smoke. Nevertheless, sometimes the smoke itself is very destructive; occasionally it is so destructive that it causes as much damage as the fire. Consequently, in some instances our effort may have to be directed at the smoke. This is the principle behind symptom removal through authoritative suggestion. The symptom may be removed, but the initiating factor that produced the symptom will remain untouched. Thus, there is always the possibility that the symptom may return in the same or slightly altered form. For this reason the patient must always be motivated, if possible, to accept a deeper type of therapy, if not immediately, then at some later date.

All hysterical symptoms serve a symbolic function at the same time that they control anxiety. In treating a patient by means of symptom removal through prestige suggestion, it is usually impossible to go into the dynamic significance of his symptoms. For this reason, an attempt may be made to transfer the symptom to a part of the body in which it will be less incapacitating, in the hope that the symbolic meaning of the symptom will continue to be fulfilled, albeit with less damaging effects on the patient. If the patient accepts this transfer, the results are likely to be more lasting.

HYPNOSIS IN SUPPORTIVE PSYCHOTHERAPY

By taking advantage of the unique character of the relationship between the patient and the therapist that is created by the

trance, hypnosis may be utilized in the other supportive psychotherapies. Here the aim is to bring the person to some sort of functional equilibrium by overcoming his emotional decompensation as evidenced in anxiety or depression, by remedying his defenses against anxiety, by getting him to adjust to his liabilities, by expanding his assets to the full, by overcoming remediable elements in his environmental situation, by helping him adjust to irremediable elements, and by executing to the full his existing creative capacities. The goal here is, of course, less ambitious than in reconstructive psychotherapy, but in many instances remarkable successes may be achieved.

Hypnosis and Guidance

Guidance therapy is the first supportive therapy that we shall consider here. The extent of guidance procedures varies from bringing the person to an awareness of specific disturbed elements in his environment, with modification of these elements as the goal, to a more complete survey and control of every aspect of the person's life. Generally, the sicker the individual is, the more extensive is the guidance process that is utilized. In many instances, a guidance approach produces results rapidly, especially where one has a limited goal in mind. If a person is extremely sick and cannot function except under the aegis of a stronger individual, guidance may be the only therapy that is meaningful for him. It must be remembered, however, that the very essence of guidance is authoritarianism and that the person improves only in so far as he maintains faith in the therapist. If guidance is not supplemented with another type of therapy in which the person takes over the choice of his own goals and values, his treatment will usually be incomplete.

Hypnosis and Reassurance

Another supportive therapy is reassurance, in which an attempt is made to overcome misconceptions of the patient by persuading him to accept the opinions of the therapist. People need various kinds of reassurance, especially in sexual areas. In our culture,

sexuality is subjected to so many distortions and misinterpretations that many individuals come into adult life with the idea that past sexual feelings and indulgences have irreparably harmed them or their sexual organs. There are also misconceptions about the inheritance of mental illness and about insanity in general. Because the patient must first accept the authority of the therapist before accepting reassurance, hypnosis is ideally suited for this type of treatment. The same limitations and precautions that apply in symptom removal apply in reassurance.

Hypnosis and Persuasion

Another therapy to be considered is the technique of persuasion. Here the patient is urged to adopt a new philosophy toward life by accepting his weaknesses, modifying remediable elements in his environment, and adapting himself to irremediable ones. Success in persuasion is contingent upon the acceptance of the therapist as a powerful and benevolent authority whose mandates cannot be countermanded.

Hypnosis and Desensitization

In the technique of desensitization, the patient is brought face to face with painful aspects of his personality through verbalization. Many people harbor attitudes, fears, and conflicts that they do not dare to divulge to themselves—let alone to others. In desensitization the patient is given an opportunity to talk about his feelings. His ability to verbalize material that is painful to him often has a cathartic effect, bringing about a gradual acceptance of the implications of this material. Desensitization—or confession and ventilation, as it is sometimes called—is most generally applicable to problems of which the patient is aware. Hypnosis is helpful in facilitating verbalization by permitting the patient to deal with anxiety that may paralyze his capacity to talk. If the disturbing material is of a subconscious or unconscious nature, an uncovering process is essential before the patient can verbalize this material. Hypnosis is useful here, too,

since by modifying repressions it expedites the uncovering of material that has been shunted away from awareness. This use of hypnosis will be considered later when the technique of hypnoanalysis is discussed.

Re-education with Hypnosis

Hypnosis is utilized in some forms of re-educational therapy. The object here is to lead the patient to an understanding of his distortions in interpersonal relationships, which are of either conscious or unconscious origin. The aim is to assist the patient toward a more harmonious integration with his environment by inculcating in him new adaptive goals and attitudes that are in line with normal biologic and social needs.

The following transcribed recordings illustrate how hypnosis may be employed in supportive therapy. The first recording deals with an obstetrician's hypnotic reassurance of a pregnant patient who was morbidly fearful of childbirth by giving her suggestions to the effect that she will deliver her child with relative equanimity. As a result of these suggestions, the patient went through labor remarkably free from pain and anxiety and had a gratifying reaction in the post-partum period. The patient has been trained to enter a trance state by repeating a number—in this case 7020.

. . . DR.: Please sit in a chair beside my desk. Get yourself in a comfortable position. Hold your hands in your lap. Don't cross your legs. Sit in a comfortable position. Now think of the number seven, o, two, o, and you will fall into a sound, peaceful, healthy sleep. You're becoming sleepy, very sleepy; sleepier, sleepier, sleepier. Your whole body feels as heavy as lead. You are getting further and further away, and you have a feeling of floating away on a cloud. You're falling into it. Keep going into a sound, peaceful sleep. (*Long pause.*)

I'm going to count to three, and when I reach the number three, you will be in a deep, sound, and peaceful sleep. One, you're getting sleepier and sleepier, sleepier. Seven, o, two, o means sleep, sleep. Two, your body feels as heavy as lead; your arms and legs are numb and heavy. You're falling into a deep, sound, peaceful sleep. You will shut out all

sounds except the sound of my voice. Other sounds are not important. You'll hear nothing, but the sound of my voice. You will obey every command and do exactly as I say. You must obey. Now sleep, sleep, deep sleep. I repeat the number, seven, o, two, o. You will sleep deeply. Three, you are now in a deep, sound, peaceful sleep. I repeat the number seven, o, two, o, seven, o, two, o. You must immediately fall into a deeper sound sleep; a peaceful, healthy, refreshing sleep, deep sleep. Listen carefully to what I say now. You're sleeping deeply now, aren't you?

PT. (*Softly*): Yes.

DR.: You are able to speak; continue to sleep. As you answer, you will fall into a deeper, sound sleep. Now, during your labor you are going to have no cramps, no pain. Labor will be pleasant. You will enjoy pushing that baby out. You will have no fear, no sense of panic. You will remain calm, peaceful, with a feeling of happy expectation. You will have no feeling of danger or sense of anxiety. You will feel perfectly safe. You will carry through normally until the baby is born. Sleep deeply now. (*Long pause.*)

I want you to repeat after me, now, this sentence, "During my labor and delivery I will have no cramps and no pain. I will enjoy my delivery." (*Patient repeats this.*) Now repeat, "Whenever I hear the doctor say the number seven, o, two, o, I must immediately fall into a deep, sound, peaceful sleep." (*Patient repeats this.*) I'm going to count to five, and when I reach the number five, you will wake up. You will feel refreshed, relaxed; you will have every confidence in this method, and you'll feel very happy. You'll feel good all over. One, two, three, four, five. Wake up.

In utilizing reassurance, we must bear in mind that although it may help the patient to gain mastery over certain superficial problems and fears, it is not very successful in really basic personality difficulties. Because success is rooted in the acceptance of the omniscience of the therapist, it is essential that reassuring suggestions be given only after the patient has developed sufficient faith in the therapist; otherwise, failure is inevitable.

Where any type of re-educative or reconstructive therapy is to be attempted, reassurance should be minimum if it is employed at all. Responsibility for handling his problems must be borne by the patient if he is to be brought to the maximum level of personality

growth. There are, however, instances in which reassurance is helpful and even necessary. In such cases an effort should always be made to get the patient to accept deeper therapy.

The next transcribed recording concerns a patient who had a somewhat incapacitating compulsion neurosis. He had been treated unsuccessfully with psychoanalytic therapy for a number of years but finally thought he might be able to control his symptoms through hypnosis. The entire treatment consisted of seven sessions, during which an authoritative, persuasive approach was utilized. In the trance state strong suggestions were made to the patient to persuade him to cultivate a new philosophy of life, which was aimed at facing his weaknesses, and to adopt an attitude of self-tolerance. Magical notions of death and dying were outlined to him as a product of superstitious misinterpretation. An attempt was made to inculcate in him a more scientific attitude toward life. The patient was encouraged to express his assertiveness and aggression when any occasion merited such expression. Improvement was rapid, and mastery of symptoms was satisfactory. During the five years since therapy was completed, the patient has functioned satisfactorily. Periodically he has bouts of anxiety accompanied by a temporary return of symptoms; but, except for three visits to me, he has managed to overcome his difficulties by himself. He works well and lives in reasonable comfort, which is quite an accomplishment for a patient who has so serious a problem.

The following excerpt is from the fourth session and contains an example of persuasive suggestions given the patient during a trance.

. . . DR.: As you sleep, I am going to give you suggestions that will help you conquer your fears. Whenever you find your mind filled with fears, divert your attention to things other than your fears, realizing that there is little basis for them in reality. You have operated on the basis of superstition and magic, fearing that certain numbers will bring you harm. Yet you know that science contradicts this. You will accept natural law more and more and gradually stop teasing yourself with superstitions. Remember, the more you tease yourself with fears, the harder it

is to control their force. You must divert your attention from them to things in your immediate environment. Now sleep deeply. (*Long pause.*)

I'm going to talk to you and suggest certain things that I want you to absorb. You have minimized your own capacities and have envisaged yourself as being an inferior person with inferior qualities that make you shy away from people. You have been burdened by a sense of inferiority that's monumental. I'm going to suggest now that you evaluate yourself a little more realistically in terms of what you actually have achieved in life. I want you to be able to absorb reality in terms of the fact that you begin to see how you've run away from feeling like an estimable person. Realizing this, you're going to start feeling better, even better than you felt last week. You're going to get better. You're going to become more confident and more self-assured. As you get better, you will not be so much concerned with the business of numbers. You will take that in your stride and pay no attention to that. You understand me?

PT.: Yes.

DR.: And you are going to get better?

PT.: Yes.

DR.: Good.

At the sixth session, the patient was taught the technique of self-hypnosis. The following excerpt from this session consists of suggestions made to the patient while he was in a trance:

. . . DR.: I'm going to turn over to you the authority to make your own suggestions in line with our work. You have been able to take over suggestions that I have given you and to utilize them to conquer fear and anxiety so you can permit yourself to live a life that is not constantly riddled by tension. You have been able to follow suggestions, have done quite admirably. It is essential now that your own self, that your own sense of strength be built up to a point where you can do these things for yourself. I am going to transfer over to you the ability to do these things, to take over, in order that you can carry on on your own. Do you understand me?

PT.: Yes.

DR.: Now, I should like to have you take all the suggestions that I have been able to give you, that you have followed to now, and begin practicing giving them to yourself. For instance, we shall start by your

putting yourself to sleep. I want you to teach yourself how to put yourself to sleep. First sit in a chair, relax, put your hand on your thigh, watch your fingers separate, slowly lift, and then your hand will rise and lift straight up in the air. Your hand will get lighter and lighter, in proportion to how sleepy you feel. So that when you watch it and notice it lifting, your eyes get sleepy and heavy and you begin to feel that you are dozing off. Your hand will rise and lift straight up until it touches your face. As soon as your hand touches your face, you'll feel yourself to be in an extremely deep sleep. Then you can continue to give yourself the same kind of suggestions that I have given you. Now, open your eyes and awaken and try putting yourself to sleep.

(Patient follows this suggestion and enters a self-induced trance.)

Good. Now I want you to go ahead with the other suggestions that I've given you. Tell yourself that your arm, your left arm is beginning to feel heavy and rigid and stiff—just as heavy as a board. I want you to tell yourself that your arm is getting heavy and stiff. I want you to keep repeating it to yourself until you begin to feel your arm getting so stiff and heavy that it's impossible to budge it, no matter how hard you try. Now, keep telling yourself that; keep telling yourself that until you find that your arm is so stiff and so heavy that no amount of effort can possibly move it. As soon as you find that this works, indicate that it's working by your right hand rising up about eight inches. When I see your right hand rising up about eight inches, I shall know you have been able to achieve the ability to make your arm heavy and rigid so that it will not move. *(Pause.)* Your hand rises now. Good.

Now, I want you to begin to develop a feeling of numbness in your hand, in your left hand. I want you to tell yourself that gradually your hand is becoming numb, that it gets more and more numb and that when you pinch it, it begins to lose its feeling. The harder you pinch the less feeling there will be. And I want you to give yourself that suggestion, and then to test the numbness by taking your right hand and pinching your left hand, so that you realize it is numb and that pinching produces no pain. I'm going to repeat that suggestion. I want you to tell yourself that your left hand is getting numb, that it's as if you're wearing a thick, heavy leather glove, and when you pinch your left hand, it's as though you're pinching a thick, heavy leather glove. As soon as you get the sensation that you are wearing a heavy leather glove, move your right hand over to your left hand, and start pinching your left hand. If your left

hand feels numb, then the right hand will rise up in the air about eight inches to indicate to me that you've been able to follow that suggestion, to give yourself that suggestion.

(Pause during which patient executes these suggestions.)

Now you've pinched your hand, and you've noticed that it has become numb through your own suggestion. *(Pause.)* I'm going to give you the suggestion now that it will be increasingly possible for you to develop the ability to give yourself therapeutic suggestions. I am going to talk to you, and as I talk to you, it will be possible for you to incorporate what I say in a constructive manner for your own good. I'm going to suggest to you that you begin to feel that you are conquering your neurosis, that you are conquering the anxieties, that you are conquering the fears of death. I want you to tell yourself that you may possibly have certain doubts in your mind, that you may possibly have residual fears, but that you will let neither the doubts nor the fears undermine you. You will continue to work in a positive direction; you will continue to do things in a self-confident and aggressive way; you will be able to plan your life so that you will circumvent being victimized by fear and anxiety.

I want you to tell yourself that the fears that you've had, the difficulties that have come to you, can be explained on a scientific basis. They relate themselves to insecurity and to problems in self-confidence. As soon as you get more self-confidence, as soon as you feel more secure, neither doubt nor fear will exist. It may take time for you to be secure, time for you to overcome all the basic fears. Do not be impatient; you can do it. You must do it. You will get better and better. You'll get better and better, and you'll find that it will be possible for you to overcome your doubts and your fears. It will be possible for you to take up life and to get from it every atom of happiness. These positive suggestions will be helpful to you and make it possible for you to direct your thoughts into constructive channels. You'll find yourself improving and getting better and better. You will find that you will function better with people, that your self-confidence will grow, that you will take things less seriously, that you will not worry so much.

At the seventh session, the patient was symptom-free. He appeared ready to terminate therapy, which I neither encouraged nor discouraged; rather, I left the decision to him. The following excerpt is from this session:

. . . DR.: The reason I have taught you how to do these things for yourself is so that you will not become dependent. There is a definite danger that you can become dependent upon any person who gives you help.

PT.: Yes.

DR.: Like myself. And this will merely increase your sense of inferiority, the feeling that you can't cope with things yourself.

PT.: Yes, as a matter of fact, I—that's the very thing I've been thinking about, at least that I'm thinking of. I'm—I've gotten off to a good start, now. I'd like to . . . I need a little extra margin of thinking for myself. You don't forget, do you, when you have a problem of something that's fifteen years behind you? On the other hand, it's a blow that I may want to become dependent, that I don't want to be self-reliant. Well, I can appreciate that. Well, I feel that at the present moment I've got this thing under control, and I feel that, uh, I have the proper understanding of it, or I've got a feeling that. . . . Let's put it that way, that I've got a feeling about this thing as never before. Because of reassurance, frankly reassurance, I felt—I'm convinced—I think I can go on with it by myself.

DR.: We're going to do a little more together, and I'm going to ask you to decide just what you feel you'd like to do next. Bearing in mind that continuous treatment may give dependency, and bearing in mind also that you have quite a serious problem and are a little shaky about your confidence in handling this and will therefore need more help. The reason that I have taught you to work with self-hypnosis is to instill in you a sense of faith and confidence in your ability to produce certain changes within yourself. Now I want you to decide whether you feel that you can handle this thing yourself, or whether both of us go ahead and continue along the lines that we have been going.

PT.: I do want to resort to self-hypnosis at times. But in the event that I do, what is the procedure along the lines of encouraging myself? Strengthening myself, is that it?

DR.: Along the same lines that we've been working, toward an understanding that these problems from which you've been suffering are due to inner turmoil, to a sense of helplessness, to a sense of self-devaluation, a sense of feeling that you don't amount to very much, a sense of insecurity. Once you see that, you will no longer be helpless in the face of overwhelming terrors.

PT.: Well, in a sense I proved I can do it.

DR.: You've proven that in a relatively short time you've been able to take hold of this thing yourself. You've been able to do something about it. You really want to do something about it. The reason you've seen all those doctors, and read all those books is that you did have a strong drive to get well.

PT.: Well, isn't that true of every person who has a mental problem?

DR.: To some extent, unless it exists for so long a time that a person gets helpless and hopeless and feels he can't do anything about it. How many psychiatrists have you seen?

PT.: Well, let's see. I guess about five.

DR.: About five psychiatrists.

PT.: Five or, well, it's been around that figure.

DR.: I see. (*Pause.*) Now suppose you put yourself to sleep.

PT.: Before I do, will you repeat the suggestions I'm supposed to give myself?

(*Patient induces self-hypnosis.*)

DR.: Now I am going to give you suggestions you can give yourself. You'll be able to feel, really feel, an ability to utilize this method if and when you need it. In the event any doubts or any fears still arise within you, you will be able to put yourself to sleep and to give yourself constructive, helpful suggestions that will restore your equilibrium. You may tell yourself that your problem stems from insecurity, from inferiority feelings, from a sense of helplessness that is a residue of early insecurities. As a result of those insecurities you may feel you're at the mercy of forces that you cannot control. Whenever anything occurs to upset you, it seems that your self-confidence gets vitiated, that your self-confidence has been undermined. Tell yourself the feeling will pass, will go away, will go away. You are stronger than your fears. You will be able to overcome the fears that have tortured you for so long. Tell yourself that, and you will begin to feel a sense of strength, a sense of productiveness, a sense of growth within yourself. Do you understand?

PT.: Yes.

DR.: You do? You will be able to manage your life in such a way that you will feel that you are not being interfered with or hurt. It will be possible for you to get better not only in your ability to control your symptoms and to feel free from anxiety, but furthermore to actually correct the basic inferiority feelings that have existed so long inside of you.

And it will be very important for you to do something constructive about yourself. Whatever method you use is immaterial, so long as you get the proper approach to life. When you put yourself to sleep, give yourself the suggestion that you're going to feel better and get better, that it will be possible to feel stronger within yourself as the days go by. Tell yourself that this fear, this insecurity need not overwhelm you any longer, that you are stronger and can be stronger than your fears. It will not be necessary for you to keep remonstrating with yourself; it will not be necessary to protect yourself all the time with devices, techniques, gestures, rituals, because you will actually feel that you've grown, are stronger, and that you can conquer your fears. You will do this because you've gotten a more healthy respect for yourself. You understand me?

PT.: Yes.

DR.: Good. Even after you finish treatment, at any time you feel that you need help, that you want help, you can contact me. However, you will also feel that you have the ability within your own self to help yourself with your problems. (*Pause.*) When you wake up, you will decide whether you can handle this by yourself or whether you want to continue seeing me further. This will be up to you. Suppose now that you wake yourself.

(*Pause. Patient awakens and decides to terminate therapy to determine whether he can handle matters by himself.*)

It may be seen from the above that in cases in which psychological analysis of a person's problems is impractical or impossible persuasive therapy provides him with a mental crutch. The substitution of persuasive philosophical precepts for destructive habit patterns is probably the lesser of two evils. Some obsessive-compulsive personalities do remarkably well with persuasive methods. Indeed, they seem to respond better to persuasion than to psychoanalysis. In persuasion, as in guidance and reassurance, an effort should always be made to bring about a change in the relationship from directiveness to nondirectiveness and to work with the dynamic roots of the patient's problems in an analytic way whenever possible in order that the patient may obtain insight into his difficulties and a better understanding of himself.

HYPNOSIS IN RECONSTRUCTIVE OR ANALYTIC THERAPY (HYPNOANALYSIS)

Recognition that the most important determinants of behavior are unconscious in nature is of paramount consideration in constructive or analytic therapy. The aim here is to bring to awareness repressed elements of the personality, to demonstrate to the individual how his impulses and drives create symptoms, to show him the functions of his drives, and to explore their purpose and genetic origins. The goal of reconstructive therapy is a drastic reorganization of the personality structure, a liberation of the self from the inexorable standards of the conscience that contain the introjected disciplines of early authorities, and a bringing of the ego to a mature level of integration, at which it can express basic biologic and social needs in conformity with the mores of the group. Unfortunately, the individual always seeks to maintain his status quo, to protect himself by resistance against change.

It is in the resolution of resistance that hypnosis exerts a striking influence. The mere induction of a trance may suffice to bring repressed elements to awareness. In most instances, however, special techniques will be required, such as free association in hypnosis, dream induction, automatic writing, hypnotic drawing, play therapy, dramatic acting-out, regression and revivification, mirror gazing, and the induction of experimental conflicts. It is, of course, not essential to utilize all these techniques. As a matter of fact, relatively few of them are actually needed, the most important being dream induction, free association under hypnosis, regression and revivification, and the induction of experimental conflicts.

For practical purposes, hypnoanalysis may be employed in three ways. The first is to make possible the development of a transference neurosis with its analysis in the traditional psychoanalytic sense. The second way is to produce desensitization, in which the patient is helped to become aware of, and to adjust to, repressed elements of his personality. The third way involves re-education of the patient

through analytic insight gained during therapy. In desensitization and re-education, a neurotic transference is avoided as much as possible.

Analysis of the transference during hypnosis usually implies that the therapist has himself been psychoanalyzed and has had supervised clinical experience. This is essential in order to avoid problems of counter-transference.

Transference in Hypnoanalysis

Analysis of the transference in hypnoanalysis may be illustrated by the case of a patient who had a psychosomatic migrainous headache and who insisted at the first visit that I prescribe sedatives for him. The patient was told:

The prescription that I'm going to give you will be much better than medicine. It is going to be a prescription that may take possibly a little time; but this thing did not develop last week. What I am going to ask you to do is to connect up for me your headache and any fears or conflicts or problems that exist in your life. Once you do this, your headaches will have the best chance of disappearing, because you will then be able to take the steps necessary to correct the cause. If I fail to give you medicine, it is because medicine does not help the kind of problem you have. You must be patient and work this thing out with me. Relief will then come.

The patient was somewhat dismayed at my reaction, and he retorted:

But I don't see any real connection between the headache and what I'm doing. Sure, I wish I had a better job, and I wish that maybe I could get more sleep, but everybody has that. I don't have anything worse than anybody else. I'd like to have some more money. I'd like to be able to travel and see this and that, but I'm not any more dissatisfied than most of the people that I know. So, even though you say that maybe there is some connection, I don't see it.

An attempt was made to show the patient that the most important difficulties in a person's life need not be conscious, that problems

might exist of which he was not aware, and that we would try to work out these problems if he would cooperate with me.

The patient was obviously skeptical, even though he promised to cooperate. No discernible change in his attitude was noted in the next few sessions except that he became less and less expressive and sat in his chair expectantly, as if he believed something important might happen to him soon. Hypnosis was started, and the patient was found to be a good subject.

Under hypnosis a suggestion was made to the effect that he would experience posthypnotically a hypersensitivity of his right hand, even though he would not remember that such a command had been given him. Upon awakening he complained of tenderness in his hand, but he was unable to understand why this was so. He was puzzled by the fact that a suggestion made to him in the trance could influence him in this manner. At the next session, he was told, prior to the trance, that I would suggest to his unconscious mind that his left hand become numb when he awakened from hypnosis. He was amazed that my prediction was correct. I then explained to him how the unconscious may influence any organ in the body. Fears and conflicts, I assured him, could reflect themselves in disturbances of the various organs, including headaches. It was possible that his headaches might be so determined. I urged him to observe the things that might cause his next headache.

At the next visit he remarked that he had had a headache. He said:

I can see no reason why I had the headache. I suppose I could tell you what happened during the day. I went to work, and everything went along pretty well. I did my job as well as anybody there, and I went home and I expected to go bowling with a friend. Now this friend called me up, and we were supposed to go out on the date. He said, "Supposing I meet you at eight o'clock." And right at that point my wife, who had been coming down with a head cold, says to me, "Why don't you postpone your going out until later on, after the kids are in bed or tomorrow?" And she did have a terrible cold. So I told my friend we'd go out the next day. I didn't want the kids to get the cold, so I put the kids to bed

and then I sat on my wife's bed. She was sniffing, and I began getting an awful headache right at that point. And there was no reason for it.

When asked whether he might have resented the fact that he had to stay home and put the children to bed, he remarked:

No, why should I? The kids would have gotten a cold. I could have bowled the next day; there's no reason why I should.

The patient was assured that perhaps there was no cause for the headache that we could see at this time, but that it was necessary to continue observing the circumstances under which his headache developed.

One week later the patient reported a severe migrainous attack.

Again I had an awful headache. Things went around. I had a bunch of junk last night, and it was probably what I ate.

When asked to talk about the events that had occurred, he said:

We went over to call on some people we know. They are nice people, but I don't care very much for them. But my wife thinks that because he is my superior at work we've got to cultivate them; and I suppose if I really want to go along, get ahead in my job, that I might as well try to be friends with him. So I went over there, and I sat there, and we drank a while, and we talked. They're terrible bores. I really don't like being with them. Then it started; an awful headache.

When asked whether he resented making the visit, the patient replied, "Sure, I didn't want to be there. I just resented being there." He was then reminded that he had presented two instances in which his wife had asked him to comply and that in each case a headache had followed. "Yes," he admitted. "I don't know. Maybe you've got something."

That he made a connection was evident in his reaction to his next headache. He said:

By George, you know what happened? My wife asked me to stay at home again and I didn't want to, and while I was talking, I got a headache.

Almost excitedly he continued:

When I look back, I can see the headache just comes like that. There have been innumerable times when automatically I feel as if I have to do what my wife asks me to do, that I can't say no. I say she is a reasonable person and a nice person, and I get a bad headache every time. Now, why should that be?

Under hypnosis, an experimental conflict was created: the patient imagined himself in a situation with his wife in which she insisted that he go shopping for groceries when he really wanted to go to a bowling match. Nevertheless, he complied with her request. He was told that when he awoke he would feel exactly as though he had executed her command but that he would not recall the situation suggested to him. Upon awakening, the patient had amnesia for the trance events. He complained of an excruciating headache for which he was unable to account. He was rehypnotized, and the nature of the experiment and the meaning of his headache were explained to him in terms of resentment at having done something against his wish.

At this point real analytic work began, since the patient was able to concede the fact that his headache had a source in what was happening to him in his daily life. A motivation to inquire into the source had been created. He was told:

So you do see a connection between your life situation and what has happened to you? Now, that's a rather interesting situation, isn't it? Here you notice that things happen at home; you've never been aware of them before. A headache occurs when your wife suggests something that you resent or that makes an imposition on you. Supposing we start inquiring into that, and supposing you, yourself, begin to figure out for yourself, with my help, what goes on here.

He retorted:

Well, can't you do that for me? Can't you tell me why?

This explanation was given:

If I told you, it wouldn't do you any good. But if you figure things out for yourself, the insight will stick.

The therapeutic situation was clarified by pointing out that he was now convinced that the headache was not mysterious, but had an origin in certain attitudes, that he would want to figure things out more in detail, and that his inner strength would increase if he figured things out for himself. The purpose behind these remarks was to motivate him toward accepting a more nondirective type of relationship with me.

When it was ascertained that he understood the need for more activity, the technique of free association under hypnosis was described to him. He readily agreed to try this technique and decided to lie on the couch for this purpose. After several sessions, during which he discussed certain resentments toward people that had bothered him, he expostulated in an irritable way that nothing seemed to be happening.

I just can't seem to figure things out. I can't seem to make any sense out of what I'm saying or why I lie down here. I can't possibly arrive at the reasons why these things go on inside of me. Now, why don't you tell me? Why don't you tell me what's going on, and why do I get these headaches?

Emphasis was again placed on the need to work things out for himself. He replied:

But I'm trying to, and nothing happens. All right, I'll try.

At this point he began to complain of a beginning headache and he started rubbing his forehead.

I can't see how my wife is responsible here because nothing has happened. I've had several awful headaches in the last couple of days, and I can't see the sense in it.

As he talked he became critical of the technique of free association. He then revealed a dream of fleeing from a dangerous man

who had plugs in his ears. He associated the ear plugs with a stethoscope. He remarked:

This man, he had a stethoscope, and he was chasing me, and I didn't want to do what he wanted me to do, and I felt he was going to hurt me and so I ran.

In reply, I said:

Is it possible that you are doing something now that you don't want to do?

He retorted:

No. I want to get well. I want to do what you say. I want to do everything you say, even though I feel that it's not exactly what I want to do. I want to do everything you say.

The reply was this:

Well, it seems apparent that you are developing toward me the same type of feelings that you have toward your wife. Here you feel I'm forcing you to do something you really don't want to do. Aren't you doing exactly with me what you do with your wife? Aren't you complying with me in doing free association and trying to figure things out for yourself when you would really like to sit up and have me tell you what to do?

At the next session the patient reported a dream.

There is a baby, a tiny baby in the arms of its mother. The mother is stuffing a nipple of a baby bottle down the child's throat. The child yowls and screams and shakes his head, and as he shakes his head, he bangs it against the wall.

The patient then exclaimed:

I have a terrible headache, one of the worst headaches I've had.

It was pointed out that the banging of the baby's head in the dream might symbolize a headache. The patient agreed that his head felt as though he were banging it against a wall. Free associa-

tion in the waking and hypnotic states yielded little except complaints about his misery and his difficulty in thinking clearly.

In the trance state the patient was regressed and was asked to return to the time when he had first experienced a headache in childhood. The period to which he returned was when he was six years of age. His mother had put him in a baby swing. He had wanted to play in the open with the other children, but his mother refused to permit him to do so. He screamed in rage, but he was forced to sit in the swing. He then developed a headache.

He was returned to an adult level, and his attention was directed to the association in his early memory between his headache and his mother's forcing him to do something he did not want to do. He admitted this and agreed to explore the matter further. Upon awakening he remarked:

I remember a dream I had. It was about myself as a child. I was in the park and mother held me in a swing when I wanted to play around with the other kids. I got an awful headache.

Following this the patient spent several sessions in violent abuse of his mother. She had overprotected him, he insisted, and she demanded compliance as a reward for her love. He felt powerless to resist her demands. He recalled many episodes of having to swallow his pride and of having to conform with his mother's commands without revolt. The aftermath of each of these episodes was a violent headache. The patient was then able to connect his past relations with his wife into this pattern, and he could also see that he had developed the same kind of attitude toward me in complying with my suggestion that he utilize an analytic technique and do free association. He could see that he entered automatically into a type of relatedness with people in which he did what was expected of him without questioning its propriety. The result was always a headache.

Soon afterward the patient began to express open revolt against his wife's demands. He could see that in feeling hostile toward her he was beginning to challenge his need to comply. Headaches be-

came less and less pronounced. In the therapeutic relationship, too, he became more openly aggressive.

The next step in therapy was to show him that his compliance and passivity were the products of his own doing. In his relations with me he was always exceedingly formal, even obsequious at times. He was extremely punctual about his appointments. On one occasion he came in a few minutes late. He was profoundly apologetic about this and spent some time trying to convince me that he had no resistance. This gave me the opportunity to point out to him that he seemed to need to do what was expected. It was possible that he maneuvered himself into a role in which he had to act compliantly, perhaps even forcing people to act in a domineering way to him.

The patient accepted this interpretation and later reported that he had observed himself with his wife. Although she did dominate him, he actually maneuvered her into a position where she took a protective role. He seemed to feel so helpless within himself that he automatically believed he had no right to resist her requests. I then brought to his attention the fact that although he might see these things, nothing would happen unless he did something constructive about them.

With some trepidation the patient began to act more forcefully with his wife. He made decisions and assumed a more and more dominant position in the household. He discovered that he could disagree with his wife and resist demands that he believed to be unreasonable and that she adjusted to his new attitude toward her. Indeed, she seemed more contented in many ways. Life began to assume an entirely different aspect. He had tested himself and found that he did not have to be compliant nor submissive. He did not have to sacrifice his integrity and his sense of self. With this reoriented attitude, his attacks of headache disappeared completely.

Transference feelings are often released during the trance state, and their proper handling is of inestimable value in reconstructive therapy. This may be illustrated by a transcribed recording of a patient who suffered from anxiety and intense depression. Much of

his depression was rooted in a fear of ineffectuality, inability to compete, feelings of hopelessness, and notions that he could not possibly get along with other persons. In the trance state, the patient suddenly identified me with his father, whom he accused of abandoning him on the post-office steps. This was an actual repetition of a traumatic incident that had occurred when he was approximately four years of age. Although he remembered some of the incidents related to this memory, he had forgotten most of his intense emotion that had accompanied the event. The memory apparently epitomized for him feelings that he had been displaced in the affection of his parents by the advent of a younger brother. The integration of this memory into his conscious life, the understanding of the emotions related to the memory, enabled the patient to see what was happening in his immediate life situation. In this portion of the recording the patient is in a trance and is given suggestions to regress to a significant period in his life.

. . . DR.: Visualize yourself as a little boy. And as a little boy you enter a schoolroom and you see a blackboard. You approach the blackboard. You walk over to it with a piece of chalk, and then you scribble on the blackboard a series of numbers. As you scribble them, repeat them to me.

PT.: Five, four, two, five, four, two.

DR.: Now take the eraser and erase the blackboard. Now as you notice the blankness on the board, you find it difficult or impossible to remember the numbers. As soon as you do that, tell me about it. (*Pause.*)

PT.: I don't remember.

DR.: Now, as you lie there, you are going to start feeling yourself getting small; you are going to feel yourself getting tiny. Your head will begin to feel small; your arms will get small; your legs will feel as though they are shrinking. You get a sensation of getting little, very little, and when I talk to you next, you will be a little boy. You will feel like a little boy, and you will be at a time of your life where something important is happening to you. I want you to tell me about it. Tell me about it without waking up.

PT.: I remember it—before Charles was born, when I was four. My father took me downtown with him. He left me. Nobody knows what

happened to me. I was brought home. I remember I am sitting on post-office steps, sitting there alone, and I am crying. I have on my gray suit. Mother bought me this suit; it was very handsome. I was brought home in the afternoon. I remember it was night. All that's ever happened to me, happened that day. My eyes hurt and burn; my throat is tight.

DR.: You're going to be able to understand what these things mean.
(Pause.)

PT.: (*Emotionally.*) You know how I feel now.

(*Hysterical laughing.*)

DR.: How do you feel? Tell me about it.

PT.: I was turning around and putting my arms around—for God's sake don't leave me—don't leave me. (*Cries.*) Don't leave me.

(*Hysterical crying.*)

DR.: Why do you feel that I am going to leave you?

PT.: I see another. You're going to leave me for another.

DR.: For what sort of another?

PT.: Tall and dark . . . you are going to leave me on the post-office steps.

DR.: Why would I leave you?

PT.: Because you loved him more than you did me.

DR.: Perhaps that's why you had the feeling that you are being left?

(*Hysterical laughing; then a whisper.*)

PT.: Maybe I am.

DR.: Now you are going to experience feelings toward me. I want you to look at me with your eyes closed, and as you look at me with your eyes closed, and as you visualize me, you are suddenly going to have a series of pictures of people I resemble, whom I remind you of.

PT.: Like father, like a man I once saw when I was on a train. . . . I used to lisp as a child; my father made fun of me. I still lisp a little. When I lisped, everyone made fun of me.

It is apparent from this transcription that the patient, while reacting to me as if I were his father, was still capable of retaining a certain amount of objectivity.

Desensitization in Hypnoanalysis

When hypnoanalysis is utilized for purposes of desensitization, the objective is to help the patient achieve awareness of

repressed memories and conflicts and to deal constructively with the associated emotions. Desensitization is especially useful in the treatment of hysterical conditions and both military and civilian types of the traumatic neuroses. Understandably, mere recall in itself changes nothing in the basic character structure of the individual. The only thing that changes is that the person is liberated from some of the effects of repression, from some of the influences of his conflict and its associated emotions. Through interpretation the therapist confronts the patient's conscious ego with the implications of his repression. The ego may at first be unable to accept that which has been repressed, the patient being inclined to deny its validity. However, as the conflicts or memories are brought up in increasingly undisguised forms, the ego becomes inured to their influence, and the patient becomes more capable of accepting them as part of himself.

A woman in her early fifties who had developed a peculiar speech disorder that was very embarrassing to her and her family was referred to me. As the woman talked, she would suck in air, producing a whining intonation and distorting her speech so that it was scarcely comprehensible. This had been going on for more than five years. Two years of psychoanalytic therapy had had no effect on her symptom, and in desperation she had had twelve shock treatments, a course of narcosynthesis, and then a period of supportive psychotherapy. All of these efforts had resulted in failure. At the initial interview with me she felt quite hopeless about her condition and confided that she was exposing herself to further therapy merely at the insistence of her family.

During the induction process in the first attempt at hypnosis, she suddenly burst into hysterical crying, lamenting the death of a sister who had died immediately prior to the development of her speech difficulty. The violence of her lamentations can scarcely be described here. As she protested her bereavement, her speech became more and more clear. She had never, she confided, been able to cry before, because she did not want people to know how she felt. Her sucking in of air and her inability to talk distinctly apparently were hysterical efforts to conceal her true feelings, which were a combi-

nation of love for her sister, rage at being abandoned, and guilt for death wishes that she had always had toward her sibling. She must not show anybody how she feels. Her aphonia and her peculiar speech difficulty were the result of this need. With relatively short-term therapy, she was brought to an awareness of this problem. Unfortunately, she stopped treatments as soon as her speech returned to normal, which prevented her from working more intensively on the sources of her emotional difficulty.

Various techniques may be utilized to elicit unconscious memories. In some patients the simple command to remember incidents in the past may bring out an amazing amount of material. In others, resistances function to keep the material repressed, even in the somnambulistic state. Indirect techniques, such as dreaming, automatic writing, or mirror gazing, may be of help in recalling stubbornly repressed memories. Regression and revivification may also be utilized as a means of remembering events that occurred at earlier age levels. Since one is dealing with intensely traumatic material—material that has had to be repressed in order to protect the integrity of the ego, it may be best to protect the patient by urging him under hypnosis to remember only those aspects of forgotten past events and experiences that he can tolerate. He may be encouraged to bring these up only when he feels sufficiently strong to endure their meaning. In this way the patient will be helped to recover in piecemeal fashion forgotten material which he can integrate later on.

A legitimate question may be raised concerning the permanence of effect on the patient of recall of forgotten memories. As has been indicated, the blotting from awareness of a traumatic incident of memory, as in the traumatic neuroses or in certain hysterical conditions, creates an abundance of symptoms designed to protect the individual from the impact of the traumatic event and the emotions associated with it. The recall of the event and especially the accompanying catharsis of the associative emotion usually make it unnecessary to maintain any longer symptoms that have functioned to reinforce repression. This may be seen in amnesia and in certain psychosomatic or phobic manifestations. Apart from this effect, the

recall of memories does not seem to have any permanent influence. Nevertheless, the experience of recall does not give the patient a motivation to inquire further into the fallacies of his present interpersonal patterns. If he can be convinced that what he is doing now is a product of misconceptions gleaned from inimical past experiences, that present-day reality is constantly being tintured by what has gone before, that many of his existing concepts are merely a carryover of misinterpretations and fantasies nurtured in early life, that his mind is a repository of anxieties rooted in past experiences, he may develop the motivation to change his attitudes toward life and people. The recovery of traumatic memories thus serves as a means of creating an incentive for change.

Re-education in Hypnoanalysis

Hypnoanalysis may also be helpful in certain re-educational approaches through psychoanalytic insight. In such cases an attempt is made to bring the person to an understanding of the dynamic sources of his difficulty, the meanings of his symptoms being demonstrated to him in terms of repressed conflict. The person is thus brought to an awareness of his conflicts, of the influence that these have on the state of his present adjustment, of the circumstances under which his conflicts originated, and, finally, of the way in which prevailing attitudes and patterns of behavior may be modified toward a more realistic and productive adaptation. The medium in which the reintegration of attitudes is brought about is the relationship with the therapist. Transference neurosis is kept at the lowest possible level by resolving it before it becomes too disturbing. Acceptance of insight is achieved by an appeal to the intelligent, constructive forces of the personality. In this type of therapy there must be an acceptance of the benevolent authority of the therapist. Hostility and other irrational emotions must be dissipated as they arise in order that the relationship may be kept as realistic as possible.

In mapping out a treatment plan, the stages in treatment may

be roughly divided as follows: The first stage consists of establishing a relationship with the patient on the latter's own terms, provided that these are not too unrealistic or neurotic. Once the relationship is started, the therapist then begins to demonstrate to the patient the fact that his symptoms are not fortuitous, but that they have their origin in fears and conflicts which bring about difficulties in interpersonal relationships and inevitably generate tension and anxiety. Various hypnoanalytic techniques may be utilized for the purpose of connecting the patient's symptoms with their dynamic source.

The employment of induced experimental conflicts in such treatment may be illustrated by the case of a man of thirty-eight who was referred for therapy because of an inability to control homosexual impulses. These impulses prompted compulsive homosexual promiscuity that promised to involve him in serious difficulties with the law. Owing to his rigidity and the fact that he was unable to verbalize freely, a period of psychotherapy had failed to help him. During the course of his treatment he had produced one or two rather insignificant dreams. Another block in therapy was that although he recognized his behavior as neurotic, he had little real motivation to stop it and even less incentive to enter into heterosexual relationships. Indeed, he seemed completely unaware that he had any problem with women, insisting that he "liked" women as friends, but that he had no real sexual feelings toward them. He considered this attitude in no way unusual. In the course of therapy, it was demonstrated, by means of hypnotically induced experimental conflicts, that his diffidence in relating himself sexually to women was the result not of lack of desire but of anxiety.

During a trance the patient was given the suggestion that he would visualize himself in a sexual relationship with a young woman. It was suggested that he would actually feel as though he were involved in intercourse. He was further instructed that when he awakened, he would feel the emotion inspired by this experience, but that he would not remember the experience itself. When he awoke, he was panicky and announced that he felt as though he were about

to suffocate. This was the first time he had ever experienced real anxiety. In inducing another trance, it was suggested that he would have a dream that would explain to him the source of his anxiety attack and that he would, if he desired, remember the dream. He was then awakened. The rest of the session follows:

. . . DR.: What do you remember?

PT.: I guess it had something to do with a relationship with a girl.

DR.: Do you remember it?

PT.: No.

(Apparently there is amnesia for the dream, inspired by anxiety investing its recall.)

DR.: Think hard. *(Pause.)*

PT.: I don't remember.

DR.: Do you think that when you look at it objectively, you are at all afraid of women?

PT.: Not particularly. I may be afraid of some people, but I don't know that I am.

DR.: You're not particularly afraid of women sexually?

PT.: No. I think I never know what's going on in their minds, but I think that's true of my feelings about people in general. I mean, uh, but I don't have any fear of having relations with them.

DR.: And what suggestions did I give you about dreams?

PT.: Well, you suggested that I was going to have a dream I was having sexual intercourse with a girl. I mean, uh . . .

DR.: Yes?

PT.: Yeah, that was it; but I don't remember it.

DR.: Any other suggestion I had given you?

PT.: Well, you suggested that I was going to dream.

DR.: About any particular subject?

PT.: Yeah, about, I think it was, uh, I thought it was, uh, that I was having intercourse with a girl.

DR.: Anything else?

PT.: I can't remember. I think you gave me this suggestion, but I don't remember following through with a dream.

DR.: You don't recall having any dreams?

PT.: No. *(Pause.)* No.

DR.: All right, then, go to sleep again.

(The patient is again put into a trance.)

Now listen carefully to me. We are going to try to work out your problems both with men and with women. We're going to do this with the objective of liberating you from whatever anxieties that may exist. We will go just as far as you want to go. Perhaps you are or are not fearful about the situation with women. Perhaps you may get to a point where you feel yourself to be very much disturbed about anxiety, if such exists, you feel in relationship to women, but you may not want to go on further. On the other hand, you may want to liberate yourself from certain anxieties and misconceptions so that you are able to get along better with women. You'll be able to do that, and you'll feel better in the process.

Don't be afraid that I am going to push you too hard, because I won't. I'll push you just as hard as you want to be pushed. You'll go just as far as you want to go. You understand that? I think that's the only way we'll be able to make progress. If you feel that you're doing this as your own project, that you're going to go as far as you personally desire to go, it will be of most help to you.

Now listen carefully to me. I want you, as you sit there, to go into a deep enough sleep so that you'll have a dream. When you have a dream, raise this hand up a few inches.

(Pause, followed by raising of the patient's hand.)

Bring it down again. Now listen carefully to me. I'm going to awaken you. When you awaken, you'll be completely relaxed. You will have forgotten everything that happened, including the dream you just had. No matter how hard you try to remember what happened, no matter how hard you try to recall the dream, the harder you try, the more blank your mind will become. Do you understand me?

(Patient nods.)

And as you sit there, when you are awake, I will rap on the side of the desk three times. At the third rap, all of a sudden there will tumble into your mind the dream in full detail as you have dreamed it. That third rap will break up the repression, will break up the block, and you'll suddenly remember the dream. You'll realize that you had forgotten the dream, and that it had disappeared totally from your mind. You understand me now?

(The purpose behind these suggestions is an attempt to break through the repressions so as to enable the patient to remember his dream.)

I'm going to count from one to five, and at the count of five, wake up and have the sensation that you've been asleep for a long time, with your mind a total blank. It will remain blank until I rap three times, and at the third rap the dream will tumble into your mind. One, two, three, four, five.

(*Patient awakens.*)

Relaxed?

PT.: Yeah.

DR.: Completely relaxed?

PT.: Mm hmm.

DR.: And how does it feel?

PT.: Just like I've been asleep a long time.

DR.: Well, what sensation do you have?

PT.: As if a long time had passed.

DR.: One hour?

PT.: Oh, longer than that.

DR.: What do you remember?

PT.: (*Pause.*) I don't remember anything.

DR.: Try hard to see if anything comes to your mind. (*Long pause.*)

PT.: I remember the word "repression," but nothing else.

(*At this point there are three raps on the side of the desk.*)

PT.: (*Laughs.*) I just remembered a dream I had. Uh, I had taken a girl friend to the house, and we were playing records and sitting around, and we got a little more chummy. Uh, feeling her arms around me, and we get into bed. I make love to her. (*Pause.*)

DR.: Is there any emotion in the dream? How do you feel?

PT.: Good, and . . . (*pause*) . . . also funny. I'm puzzled by how I forgot the dream.

DR.: Well, what I've done is to demonstrate to you the mechanism of repression by showing you that it is possible to have dreams and not to remember them and then to have them recalled to your mind.

PT.: Mm hmm.

DR.: It is possible to have a dream and then completely forget it for certain reasons, like anxiety, or feeling uncomfortable in remembering it.

PT.: It's amazing.

DR.: It's amazing how the mind works. That [repression] is one of the mechanisms the mind utilizes to keep fears or anxieties under control.

I did this, the taps and all, so that you would know what we meant by repression.

PT.: Mm hmm. Repression protects me from fears of some kind?

DR.: Repression is produced by a desire not to remember, usually because of anxiety. Now, we're trying to work out if you have certain anxieties with women. If there are such anxieties, we should get to understand them, shouldn't we?

PT.: Mm hmm.

DR.: Because, after all, you would like to know about yourself, what is important, wouldn't you?

PT.: Mm hmm.

DR.: So, let us continue with this experiment to see if there are any areas of repression we can explore. Supposing you go to sleep again.

(Hypnosis is reintroduced, and the patient is given further suggestions.)

Now you'll carry on with the dream you had just before. You will have gone into the room with your girl friend, and you start sexual play. You start sexual play with her. And then the dream will proceed as you desire. Whatever comes to your mind, let it come. As soon as you've had that dream, raise your hand.

(Long pause; and patient's hand rises.)

Now let your hand come down again. Listen carefully to me. You'll repeat what happened before. When you awaken, there will be a complete loss of memory of the dream. No matter how hard you try to recall it, it will be completely gone. Your mind will be blank. But again, I will rap three times on the side of the desk, and on the third rap the dream will come back. And, in addition, something else will happen. If you've had any other dreams that you have forgotten, as soon as you recall the dream you just had, the other dream will return to you, and you will reveal that to me. Do you understand? Also, you will be able to put things together better. So I'm going to wake you up, and you'll notice that your mind is a total blank. As soon as I rap three times on the side of the chair, the dream will come back in a flash. You'll tell me about it, and then, as soon as you do, if you had any dreams that you've forgotten, these will return to you also. One, two, three, four, five, wake up. Hello.

PT.: Hello.

DR.: Any dreams?

PT.: No. *(Three raps.)* By gosh, a dream flashed into my mind.

DR.: A dream?

PT.: Yeah.

DR.: Tell me about it.

PT.: Yeah. This girl and I, we get in bed, and I kiss her all over. And then I had relations with her. (*Pause.*) I just thought of another dream I had. It was at a summer resort that somebody once described to me. I've never been there, but there was a very turbulent stream flowing over rocks, and there was a bridge crossing over that stream. But in order to get to that bridge, you had to walk along a bunch of rocks, and there was no railing there. You were right by the water's edge; there was nothing to keep you from falling in. And I walked along the bridge, and crossed over the bridge onto the other side where there was some hotel, some kind of entertainment place I guess. There was dancing there and music.

DR.: Mmhhh.

PT.: I think the thing that impressed me most was that there was no railing to keep you from falling in the water.

DR.: Where was the scene?

PT.: It must have been in the mountains.

DR.: What comes to your mind when you think of crossing the bridge?

PT.: I think getting to the bridge. There was no railing there to keep you from falling in, walking right alongside the water. It was dangerous, dangerous.

DR.: I see, but in order to get to this hotel you had to cross the bridge?

PT.: I wanted to get to the hotel, so I was willing to take a chance.

DR.: When was it you had this dream?

PT.: A couple of nights ago.

DR.: A couple of nights ago?

PT.: Yeah.

DR.: You had forgotten it?

PT.: Yeah.

DR.: Completely forgotten?

PT.: Yeah. I remember the meaning of the dream now. It has something to do with, as if I'm willing to take a chance.

DR.: Well, you may be able to interpret that dream, be able to understand it better. You recall that I've given you a suggestion that you

would begin to understand if there was anxiety deep down associated with being able to enjoy yourself in a sexual sense with a woman?

PT.: Mm hmm.

DR.: The reason being that once we knew that there was anxiety there, that there was some block, you would then be in a better position to tackle the block.

PT.: Mm hmm.

DR.: I suggested to you when we began working on this problem that you would have a dream which would indicate whatever anxiety there might have been associated with sex with a woman. Now, the dream you had you forgot.

PT.: Yes. I know it has a lot to do with what we're working on.

DR.: What goes on in hotels?

PT.: Women, sex. You know, I remember in the dream a friend of mine helping me across the bridge. Now, I did call him up last night to see if he could get a girl for me. I thought since we were working on this sex business, I'd go out.

DR.: To see if he could find a girl for you? Does that make the dream any clearer?

PT.: (*Laughs.*) Yes, his helping me across the stream; like you're helping me.

DR.: So that here you have that situation of his helping you, helping you across this very turbulent channel, like I'm helping you. He could then be myself?

PT.: Mm hmm.

DR.: What did the turbulent stream and the danger of falling in mean?

PT.: What might happen to me in sex.

Within a week following this session, the patient had his first successful sexual relationship with a woman. The ability of the patient to understand that it was anxiety that blocked his path toward heterosexuality was undoubtedly of great importance in enabling him to work through his block.

TECHNIQUE OF HYPNOTIC INDUCTION

The induction of hypnosis is relatively simple and may be mastered in a short time with consistent practice. Techniques of trance induction have been amply described in books listed in the references. Now, hypnotizability is a normal trait, and most people may be inducted into a trance state if too severe resistances are not present. Resistances are of both conscious and unconscious origin and take many forms, such as inability to concentrate on suggestions, shifting attention, self-depreciation, and a defiant, challenging attitude toward the operator. These obstructions fortunately are not very common and may be circumvented with a proper technique.

To illustrate the technique of induction, as well as to demonstrate how therapy may be introduced in the course of hypnosis, the following transcriptions are presented. They contain an interview with a physician who is having problems in trance induction and a demonstration of several methods of inducing hypnosis with a voluntary subject. These transcriptions point up a variety of problems involved in hypnotherapy.

The first transcription is that of a conversation between a psychiatrist and myself in which he introduces the difficulties that he is experiencing in hypnosis.

. . . DR. W: Come in. Just sit in this chair over here; make yourself comfortable, and we'll talk things over.

DR. X: Well, thank you, doctor. The problem I bring to you is that I'm having a lot of trouble with—I just don't seem to be able to hypnotize people.

DR. W: You have a problem in hypnotizing people. What type of psychotherapy do you do?

DR. X: I do a general type of psychotherapy, not a great deal of psychoanalysis. I've been psychoanalyzed myself, but most of the people who come to me—their problems don't indicate psychoanalysis, so that I thought that, in this general kind of work, hypnosis, hypnotherapy would be a considerable help.

DR. W: I see. And actually what specific problems do you have inducing a trance?

DR. X: My problem in inducing a trance in patients seems to be one of technique. I—I've read considerable about the subject. I believe in its validity. I read of the way you do it and other doctors have done it, and I've tried to do that myself. But it doesn't seem to take hold. The patient doesn't seem to react to my type of hypnosis.

DR. W: I see. Do any of them go into a trance? Do they seem to go to sleep—some of them, I mean?

DR. X: Yes. Most of the patients are sympathetic with this type of therapy, and when I explain it to them, they try to cooperate. Sometimes I'm afraid they cooperate too well. They either try to assist me or to fool themselves that they're being hypnotized, but they're in a very light trance, which I can't distinguish from voluntary cooperation.

DR. W: I see.

DR. X: I do not know if there is an acceptance of hypnotic suggestions.

DR. W: Do they say they haven't been hypnotized when they awake?

DR. X: Yes. They say they are perfectly conscious all the time, which sort of disheartens me.

DR. W: I see. Now, what specific type of technique do you utilize? Do you use the eye-fixation method, or do you use hand levitation, or do you use hypnosis through sleep suggestion, or what?

DR. X: Well, first I use eye fixation, some bright object up above their eye level in front of their forehead.

DR. W: I see.

DR. X: After that I proceed to sleep suggestion.

DR. W: I presume you prepare the patient, motivate him for therapy? I presume you go through these maneuvers?

DR. X: Well, it depends. If the patient has known something about hypnosis, and has no particular fears or resistance toward it, a great deal of preparation isn't necessary. Otherwise, if they have misconceptions or seem to have any kind of nervousness or fear, I try to explain what it is, that it isn't anything fearful or injurious, that it's just a form of accepting suggestions.

DR. W: Yes. Of course, the best way to learn to do hypnosis is to do hypnosis under supervision. Perhaps a substitute for that might be for you to observe me perform a hypnotic trance session.

DR. X: Well, that is what I hope to see in coming to you, doctor, because I've never seen hypnosis done by anyone else. I've tried this right from my own studies.

DR. W: I see. Have you ever seen any of the stage hypnotists?

DR. X: Oh, yes. I've seen those many times throughout my life at various kinds of vaudeville shows. I've seen stage hypnotists who were very theatrical and dramatic, achieving somnambulistic states in a period of approximately a minute.

DR. W: Yes.

DR. X: But they may be just better technicians than I am.

DR. W: Yes. And of course you cannot utilize their methods in therapeutic hypnosis.

DR. X: That's true.

DR. W: Now it would be very, very valuable if we could have a patient here that we could practice on. Understandably, it would be rather difficult to achieve this. But I may have a substitute that may very well take the place of an actual demonstration. I might play you a recording of a voluntary subject that I inducted into a trance, a recording of the actual hypnotic session. In it you will hear the intonations, the timing, the way phrases are spoken, which are fully as important as the content of what is said. And perhaps if I play the recording, you may get some ideas as to your own particular problems in inducing a trance.

DR. X: I feel, doctor, that that's where I'm lacking. I know all the words, but they don't produce the effect, very much as if I were to recite Shakespeare and Maurice Evans were to recite Shakespeare. They're the same words, but I assure you the effect would be quite different. But that's why I've come to you—to see a hypnotic session, just what you do, how it reacts on the patient, and how you tell the various stages of reaction in a patient.

DR. W: Fine. I'll play you the recording, and what you want to watch out for as you hear it are the following: First, you'll notice that I talk to the subject rather casually, as I try to get her ideas about hypnosis with the intent of removing any misconceptions, fears, or resistances to the trance. Then, what I attempt to do is to motivate her to accept hypnosis in such a way that she will be able to go into a trance with as little resistance as possible. Then I use a suggestibility test, the back-sway test. I don't use this test in all cases, but in some instances it's quite helpful because it gives the person confidence in his ability to enter a trance state.

Then I go right into the technique of hypnosis itself. I illustrate several forms of trance induction in the recording. I point out the method of hand clasp, the induction of trance through hand clasp. Then I introduce the technique of hypnosis through hand levitation; then the technique of hypnosis through eye fixation; and, following that, through sleep suggestions. You might perhaps utilize any of these techniques that co-ordinate best with your own personality.

DR. X: Well, since my problem, doctor, is one of beginning hypnosis, would you suggest that it would be a good idea for a presently inept practitioner like myself to use these preparatory tests, like the back-sway test and the hand-clasp test pretty consistently at first, until I became confident that I didn't need them to prepare the patient or myself?

DR. W: Yes, I believe so. I think that it might be quite beneficial, bringing you to a point of confidence in inducing a trance, for you to utilize the various suggestibility tests. Then, as soon as you get confidence in your ability to apply the hypnotic procedures, you may do away with suggestibility tests in most patients. Let's go right ahead now. I'll play the recording and then we can talk things over after that.

DR. X: Thank you very much, doctor.

The following transcription is that of a session with a subject who volunteered to undergo trance induction. As will be noted, the subject mentioned a mild phobic problem which became the focus of a later therapeutic session.

. . . DR.: Well, hello.

S: How do you do, doctor.

DR.: Won't you sit down in this chair to talk things over?

S: Thank you very much.

DR.: Well, here you are finally.

S: Yes, yes.

DR.: As you know, you're here to act as a voluntary subject for hypnosis. How do you feel about it? How do you feel about being hypnotized?

S: Well, it's a funny feeling.

DR.: What do you mean?

S: I mean, well, I mean we've all heard a lot about it, but I've never been hypnotized myself, of course.

DR.: Hm hmm.

S: And the only time I've ever seen it is on the stage.

DR.: What did you see on the stage?

(It is important to determine what the subject knows about hypnosis or imagines hypnosis to be in order to correct misconceptions.)

S: Why, I saw the hypnotist take a group of people. A group, a lot of people, came up on the stage and he hypnotized them. He hypnotized one man and just left him sitting there way over on the edge of a chair. *(Pause.)*

DR.: On the edge of a chair?

S: Yes, while he hypnotized other people.

DR.: I see.

S: And the people looked pretty droopy as a matter of fact. They looked pretty silly. He had them doing foolish things.

DR.: Uh huh. Are you afraid I may ask you to do foolish things?

S: Well, I don't know. Are you going to?

DR.: No, of course not.

S: No?

DR.: Hypnosis as it's utilized scientifically is not stage hypnosis.

S: No.

DR.: There is a whale of a lot of difference between the two. In stage hypnosis the hypnotist picks susceptible people, and then he causes them to do all sorts of fantastic things in order to get a laugh out of the audience.

S: Yes.

DR.: But in scientific or therapeutic hypnosis an entirely different attitude prevails. Of course, I will not ask you to do any silly thing.

S: Yes.

DR.: Do you have any other feelings or notions about hypnosis?

S: Well, I don't know whether it's possible to hypnotize me.

DR.: What do you mean?

S: Well, I—I can't imagine myself being hypnotized.

DR.: Well, what do you think is going to happen? What are your ideas of what happens in hypnosis?

S: I don't know. Is one completely unconscious?

(This is a very common misconception.)

DR.: That is the idea most people have. As a matter of fact, you never go into a state where you lose contact with the hypnotist. During the first few sessions of hypnosis, you're in complete control of your activities,

except those that you want to feel are happening in spite of you. And you're in contact with me at all times. You do not lose consciousness. That's a fantastic notion that people have got out of observing the antics of a stage hypnotist.

S: Well, I have a rather strong will. I don't—I don't know—I just don't feel that I will be likely to—to submit my will to another person.

DR.: You feel then that you might possibly lose your will power in hypnosis? Is that what you mean?

S: Why, yes.

DR.: That is another idea that has to be clarified. As a matter of fact, in hypnosis people do not lose their capacity for independent action. You can resist any activity or group of activities that you do not desire, really desire, to perform. Hypnosis does not work on people with weak wills. Actually, people who are mentally defective or who have very severe intellectual problems cannot be hypnotized.

S: Well, I—I wouldn't have thought of it that way.

DR.: Do you have any other ideas on hypnosis?

S: Yeah—well now, supposing, doctor, that I was hypnotized, how can I be sure that I'll wake up?

DR.: You fear that you might possibly go to sleep and that I may not be able to wake you up?

S: Yes, yes.

DR.: Hypnosis is not actually sleep. In deep forms of hypnosis, it is possible to suggest sleep to a person. But even where a person goes to sleep, deeply asleep, he will wake up after a short time. Notions that a person may be left in a trance for days or weeks are pure fiction. That just does not happen. Of course, you'll wake up. You'll wake up very, very easily. It'll be much harder for you to fall asleep than to wake up, actually.

S: And then all these things that we hear over the radio about people who have been made to do things—I mean sustained action for days and days. That couldn't really happen?

DR.: No, of course it can't. That's nonsense. (*Pause.*) Now, you do have a desire to be hypnotized?

S: Yes.

DR.: That's very important, but the incentive of just coming here to be my subject may not be enough. You may have to have some other

goal that we can shoot for. If you have any particular problems, like sleep difficulties or the like, we may be able to help you with them. Is there anything you feel I might be able to do for you in a positive way?

S: Well, I—I've been thinking of going to look for a new job.

DR.: Mm hmm, I see.

S: And the very thought of just looking for a job is just terrifying to me.

DR.: Is that so?

S: Yes. Once I have a job, I like it. I am willing to work eighteen hours a day and I enjoy everything I do; but the looking for a job is very difficult.

DR.: I may perhaps be able to help you.

(In the average patient applying for therapy, motivation in the form of suffering from symptoms is elicited without difficulty.)

S: That would be wonderful, because this really is a fear of mine.

DR.: I may be able to help you gain a certain feeling of relaxation in a job situation. And you may find that as a result of the work you do with me—perhaps not in this session, but in a later session, if you turn out to be a suitable subject—you may be able to master certain fears and trepidations in this particular situation.

S: Yes.

DR.: Then suppose we now begin to talk about what may actually be required of you during this first trance. I'd like to give you an idea, just in brief, of some of the general things that happen. First, you'll notice that you begin to relax and that you feel just a little bit drowsy. It's not necessary to try too hard.

S: No.

DR.: Just let things happen as they will. Make your mind passive and relaxed, if possible. Now, you'll become aware of certain things that are happening as you relax. I'd like to have you concentrate on these. I may even bring them to your attention. You may not be able to follow all the suggestions that I give you, but don't let that bother you.

S: O.K.

DR.: You may be able to follow some and not others. You'll be in constant contact with me, and when you wake up, you probably will remember everything that happened.

S: Really?

DR.: It may be that you may have a vague idea about certain things and perhaps even have forgotten one or two things; but in general you'll recall everything that happened.

S: Mm hmm.

DR.: You'll probably even have a feeling, when you wake up, that you might have resisted all of the things that I suggested to you. If you want to resist, you can resist.

S: That's what I wanted to ask. Should I try to do everything that you tell me to do, or should I be passive?

DR.: It's important not to do things voluntarily. Let things happen as they will.

S: Yes.

DR.: Just let things happen as they will.

S: Yes.

DR.: And don't force them. Don't push yourself too hard. If things just do not happen, well, they just don't happen.

(These preparatory suggestions are, unfortunately, too often neglected in routine inductions. Their use is strongly recommended.)

S: Yes.

DR.: I'd like to give you an idea now of what hypnosis is like. Supposing, now, you put your feet right on the floor, just like that.

S: Yes.

(Subject puts feet squarely on floor.)

DR.: And you breathe in deeply and relax yourself, just like that. Then I'm going to ask you to stand up. Stand up a moment, turn around with your back to me, and put your feet together.

S: Yes.

DR.: And bring your head up, straight up, and gaze at the ceiling directly overhead. I'm going to bring my hand right over your shoulder blades this way, and then I'm going to suggest to you, as you look up at the ceiling, that you begin to feel yourself falling back, falling back, falling back, falling back. You begin to sway a little; you begin to sway a little; you begin to sway a little. Now, I'm going to let go in a moment, and you'll feel yourself swaying. If you sway back, I shall catch you. You're resisting a little bit, and I'm going to shake your shoulders back and forth, rock you back and forth. It's not necessary to be so stiff. Just loosen up a little bit; just like that. Good. Good. Just like that.

(Subject falls backward.)

Now, I'm going to ask you to look up overhead and then close your eyes. Close your eyes. You begin to sway back. You're falling back. You're falling back, and, as I move back, you fall right back into my arms, just like that, just like that. Relax completely. All right. Good. Now, turn around and sit down in the chair again. That's what hypnosis is like—the ability to follow suggestions.

Now, I'd like to have you put your feet straight down on the floor again. Lean back in the chair, with your head comfortably back on the chair. Clasp your hands in front of you. Keep your eyes opened, but stare at your hands.

(Hypnosis through hand clasp is illustrated here.)

Keep your eyes focused on your hands. Imagine that your hands are just like the jaws of a vise, one of those heavy metal vises that you screw tight with a great big clamp. Just clamp your hands together. I'm going to count from one to five, and as I count from one to five, your hands will become more and more firmly clamped together, until at the count of five, they'll be so firmly clamped together that it will be difficult or impossible to open them. Keep staring at your hands. Now, one, they're very, very tight, tight, tight. Two, they're getting tighter and tighter and tighter. Three, they're getting so tight they feel just as tight as a vise, as tight as a vise, as tight as a vise, as tight as a vise, now, as tight as a vise, as tight as a vise. Four, tight, tight, very tight, just as tight as a vise. Five, as tight as a vise, as tight as a vise. You try to separate them, but they will not separate. They're glued together, tightly glued together. No matter how hard you try, they're stuck together.

(Subject's hands are in a tight clasp.)

Keep your eyes focused on your hands now. Keep your eyes focused on your hands, and, as you gaze at your hands, your eyes get very, very heavy. They're very tired. Your breathing will get deep and automatic, and your eyelids will begin to close. They'll begin to close; they'll begin to close; they'll begin to close. They're closing, they're closing, they're closing, they're as heavy as lead. They close, and they're going to stay shut now till I give you the command to wake up. They're going to stay shut now until I give you the command to wake up.

(Often it will require more suggestion along the same line before the subject shuts his eyes.)

You feel very, very tired, very, very drowsy. Your breathing is deep and automatic, and you're going to go into a deep, relaxed, comfortable

sleep. You're going into a deep, relaxed and comfortable sleep. You're going into a deep, relaxed and comfortable sleep. Now, I'm going to stroke your hand and your fingers, and I'm going to bring them down to your thighs, and then I'm going to wake you up after that. I'm going to stroke your hands, bring them down to your thighs. I'll bring them right down here. And then I'm going to ask you slowly to open your eyes and wake up. I'm going to count from one to five. At the count of five, open your eyes and wake up. One, two, three, four, five. Open your eyes now. Good. Just like that. Wake up. Wake up. Wake up. Wake up now. How do you feel?

S: Fine.

DR.: A little bit tired?

S: A little.

DR.: The reason I woke you up is this. I would ordinarily have had you go into a deeper trance, but I wanted to demonstrate another technique, a different mode of inducing hypnosis. We'll go through this rather rapidly. The method I am going to teach you now is that of concentrating on sensations in your hand.

(The following suggestions are for the purpose of teaching hypnotic induction through hand levitation.)

For instance, as you sit there, bring your hands straight down on your thighs. Keep gazing at your hands now; keep gazing at your hands. Keep your hands focused on by your eyes, just like that. And as you watch your hands, you'll become aware of certain sensations in your hands. You become aware now that you are sitting very, very quietly. Your breathing is deep and relaxed. Your head moves a little, but that's not too important.

(The object here is to comment on casual movements of the subject in order to link these spontaneous movements with the utterances of the operator.)

Just keep gazing at your hands. No matter where your attention is, it will keep coming right back to your hands. You may experience the feeling of heaviness. You may perhaps become aware of the heaviness of your hands as they press down against your dress, or perhaps you'll become aware of the texture of your dress against your fingertips, or it may be the warmth under the palm of your hands. Whatever feelings or sensations you have, I'd like to have you concentrate on them.

(Concentration on sensations focuses the subject's attention and creates a further association with the verbalizations of the operator.)

In a moment you'll begin to notice that one of the fingers will move a little. You don't know which finger it will be, whether it will be in the left hand or the right hand, whether it will be in the thumb, the index finger, the middle finger, the ring finger, or the little finger. It makes no difference. The movement will gradually come and you'll see one of the fingers jerk. One of the fingers will jerk a little.

(This is the first forced suggestion.)

One of the fingers will jerk a little, just like that. There, it begins to jerk. Now, it begins to jerk; it begins to jerk.

The next thing you'll notice is that the fingers will slowly begin to separate. The spaces between the fingers will get wider and wider. The spaces between the fingers will just spread, just like that, and as you keep watching your hands, now, keep gazing at this hand over here. Keep gazing at this hand over here. Keep gazing at this hand over here, and then shift your gaze to this hand over here, just like that. Keep shifting your gaze. Now back here to this hand over here, and you begin to notice a very interesting thing. The finger will begin to move up. The finger will begin to rise. One of the fingers will begin to move up and rise. It will lift a little. It'll rise and move and lift, straight up in the air; rising, rising. And then the rest of the fingers will slowly begin to lift, from the thigh straight up in the air, lifting, lifting, lifting, rising, straight up the air, slowly up in the air. The whole hand now begins to lift straight up in the air. It'll soon begin to rise and lift straight up toward your face; rising, rising, rising, slowly rising. And you keep your eyes fixed on your hands. You enjoy the movement of your hand. Your hand slowly begins to lift straight up in the air, just like that; just lifting, lifting, lifting, lifting.

Now, your hand is extended right in front of you. Keep watching your hand, and the direction of the hand will soon change so that it starts bending toward your face, moving up, up, up. Keep breathing deeply. As your hand moves up, your breathing gets deep, and you begin to fall asleep. You get very drowsy. With each breath you feel drowsier and drowsier, and as the hand begins to lift toward your face, you start falling asleep; you start falling asleep; you start falling asleep. Your hand is coming toward your face, touching your face, and as soon as it touches your face, you'll fall asleep. But you must not fall asleep until your hand touches your face; you must not fall asleep until your hand touches your face. When your hand touches your face, you'll be asleep, and you'll stay asleep now until I give you the command to awaken.

(Subject's hand touches her face and she closes her eyes.)

Just relax, comfortably relax. Go to sleep deeply, but just for about a moment, and then I'm going to awaken you again.

(The subject is being awakened in order to demonstrate another technique of induction, which is hypnosis through eye fixation.)

Now as you sit there, I'm going to ask you to bring your hand back again to your thigh, just like this, just like this. I'm going to count from one to five, and at the count of five your eyes will lift, and you'll wake up; you'll wake up. One, two, three, four, five. Open your eyes; slowly open your eyes. It's a little difficult; just like that; just like that. Just open them; just open them.

I have a little shining object over here which I place directly over your head. Keep your eyes focused on this object.

(The object may be any small shiny object held about ten inches above the head.)

Your eyes may shift from the object, but they'll go right back to it; they'll go right back to it. As you stare at the object, you'll notice your eyes get very tired. They get very heavy and tired. It's harder now to keep them open; it's harder now to keep them open. They begin to water, they burn, they feel like lead. Your eyelids get heavier and heavier, and they close; they're closing, they're closing, they're closing, they're closing, they're closing. They're as heavy as lead. You can feel yourself dozing off and falling asleep, deeply asleep, deeply asleep. Your eyes now shut, and they're going to stay shut until I give you the command to open them. Go to sleep, deeply asleep. You'll stay asleep until I give you the command to awaken, deeply asleep until I give you the command to awaken, deeply asleep until I give you the command to awaken. Just like that. *(Pause.)* Now, I'm going to count from one to five, at the count of five, wake up. One . . . two . . . three . . . four . . . five . . . wake up, wake up. *(Subject awakens.)*

Now, I'd like to have you walk over with me to a couch over here. I'd like to have you lie down. Lie down, make yourself comfortable. Just rest, rest, rest. I'm going to give you some suggestions that will put you to sleep.

(Hypnosis through sleep suggestions is illustrated here.)

As you lie there, I'd like to have you close your eyes. I'd like to have you close your eyes. Breathe in deeply, and begin to feel a sensation of drowsiness sweep over you, from your head right down to your feet;

a sensation of drowsiness sweep over you from your head right down to your feet; a sensation of drowsiness sweep over you from your head right down to your feet. You feel very drowsy and tired and sleepy. And I'd like to have you concentrate on how it would be to be asleep. I'd like to have you concentrate on sleep and how it would be to be asleep. Just concentrate on sleep and how it would be to be asleep.

Begin relaxing the muscles in your forehead. Yes. Just like that. Loosen them up. Loosen up the muscles in your forehead, just like that. Loosen them up. And then begin to concentrate on the muscles in your face. Relax the muscles in your face; relax the muscles in your face; relax the muscles in your face. Concentrate on the muscles in your face. Relax all over, all over. You're lying there very quietly now. As you lie there, concentrate on the most relaxing scene that you can imagine, the most relaxing scene that you can imagine. What is the most relaxing scene that you can bring to your mind? You can talk to me without opening your eyes.

S: Lying on the beach in the sun.

DR.: Lying on the beach in the sun.

S: Yes.

DR.: All right. Suppose you just concentrate on a scene of lying on the beach in the sun. Imagine yourself lying on the beach in the sun. The sky is blue, except for one or two billowy clouds floating overhead. You see a sand dune on one side, and on the other side you see an orange umbrella and a blue sea. The sea is very calm today. The sun is very hot. It beats down on you, and you breathe in deeply. You feel yourself dozing off as you lie in the sun. Everything is very peaceful. The clouds float lazily by, and you feel a sense of relaxation, a sense of relaxation that permeates everything. You get very tired now, and very, very drowsy. You're getting drowsier, and drowsier, and drowsier. You're getting very drowsy and tired, very tired.

I'm going to go over to you now, and I'm going to lift your right hand; I'm going to lift your right hand; I'm going to lift your right hand straight up in the air, just like that. Just loosen it a bit. It's a little rigid now. It becomes limp. There, just like that, good. It's limp; it falls down, and you make yourself relaxed all over. Just relax, just relax, just relax. (Pause.)

Now as you lie there, you're limp all over, from your head right down to your feet, just like that. Good. You're relaxed; your forehead is re-

laxed; the muscles in your face have relaxed; your neck has relaxed; your shoulders; your arms; your elbows; your forearms; even your fingers; your back; your hips; your thighs; your legs; your toes—everything is relaxed. You feel as if you're sinking right down, deep down, deep down into the couch, just like that. And as you lie there now, you'll notice that your eyes are very heavy. They're so heavy, they feel like lead. It's an effort, it's an effort to open them. Even when you try to open them, it's a tremendous effort. You see now you cannot open your eyes. They're very heavy; they're very heavy; they're very heavy.

As you lie there now, I'm going to stroke your arm; I'm going to stroke your arm, and I'm going to bring it straight up in the air, straight up in the air. I'm going to bring it straight up in the air. Your arm is rigid and stiff, rigid and stiff. It's extended right up in the air, right up in the air, just as stiff as lead. It remains up there; it remains up there, until I give you the command to bring it down. I stroke the muscles. The muscles get stiffer and stiffer and stiffer, and now I let go. I let go, and the arm is stuck right up there in the air, and, as you try to bring it down, it remains stiff, stiff, stiff, straight up in the air, just like that; stiff, stiff, stiff, straight up in the air, just like that; stiff, stiff, stiff, straight up in the air, just like that; stiff, stiff, stiff, stiff, stiff.

You doze off now; you doze off. You go to sleep, deeply asleep. You're going to doze off into a deep, deep, relaxed, comfortable sleep. You're going into a deep, deep, relaxed, comfortable sleep. You're going into a deep, deep, relaxed, comfortable sleep. Go to sleep. (*Pause.*)

I'm going to wake you up now; I'm going to wake you up. I'm going to ask you to open your eyes, and then walk back over to the chair, just walk back over to the chair with me. Open your eyes now; wake up, wake up.

(*Subject opens eyes.*)

I'm going to walk you, I'm going to walk you right over to the chair. Of course, your eyes are a little bit heavy. What I'm going to demonstrate to you now is what is done where a person has difficulty in closing the eyes.

(*Illustrated here are techniques that may be used where lid catalepsy is resisted.*)

Now, this is used in persons who find it difficult to close their eyes when they go into a trance. Of course, you don't find it difficult to close your eyes, but I'm merely doing this to illustrate the process. For instance,

if you did have difficulty in closing your eyes, what I would do is ask you to focus your eyes on my hand, just like this. And you keep your head steady as you keep looking down at my hand, and then I bring my hand up this way. Keep your eyes focused on my hand as I bring it down and up, down and up. Keep your eyes focused on my hand as I move it up and down, and as I do, your eyelids get very heavy. Your eyelids get heavier and heavier. It's getting harder to keep your eyes focused on my hand. They'll get so heavy in a moment that they'll begin to close, and you'll feel yourself dozing off. You're going into a deep, deep, relaxed sleep. Your eyelids are getting heavier and heavier and heavier. It's harder and harder to keep them open. In a moment they'll be so tired that they'll close, and you'll go into a deep, deep sleep, deep, deep sleep, deep, deep sleep. You focus on my hands, up and down, up and down, up and down, up and down. Now, your eyes have closed.

If you had resisted still, what I would have done is merely to press your eyelids together, just like this, saying to you, "Your eyelids are glued together; they're glued together; they're glued together. Now, keep them closed. Keep them closed until I give you the command to open them up." And then I'd go right ahead with the rest of the induction procedure. If I didn't do that, I would do another thing. I would, instead of putting my fingers on your eyelids, merely ask you to look at my index finger and my ring finger, and then I'd just bring them closer and closer to your eyes. You'd find it harder and harder to keep your eyes open. When I came close to your eyes, it would become necessary for you to close your eyes.

Now, I'm going to put you to sleep again, a deep, deep, relaxed sleep. Just lean back there and go to sleep, deeply asleep, from your head right down to your feet. Go to sleep, deeply asleep; go to sleep, deeply asleep. You're going into a deep, relaxed sleep now; you're going into a deep, relaxed sleep; you're going into a deep, relaxed, comfortable sleep; you're going into a deep, relaxed, comfortable sleep; you're going into a deep, relaxed, comfortable sleep. Go to sleep, deeply asleep; go to sleep, deeply asleep; go to sleep, deeply asleep. You're going into a deep, relaxed sleep.

(Subject is in a trance.)

As you sit there, I'm going to stroke your arm. I'm going to stroke your arm and your hand. As I stroke your arm, you'll notice the heaviness sweep from the shoulder right down into your arm, into your elbow, into

your fingers. Your whole arm will get very heavy as I stroke it; it will get very heavy as I stroke it; it will get very heavy, so heavy that as I stroke it, it'll feel just like lead. It will get so heavy that when I reach the count of five, it'll be impossible for you to budge the arm. It'll feel so heavy it will be as if a hundred-pound weight is pressed down on the arm. One, heavy; two, heavier and heavier; three, as heavy as lead, as heavy as lead, as heavy as lead; four, heavier and heavier still; five, just as heavy as lead, as heavy as lead. It's impossible for you to budge your arm no matter how hard you try. It remains stiff, exactly as I have pressed it down, just resting comfortably, resting comfortably on your thigh, resting comfortably on your thigh, just like that.

The next thing I'm going to do is to show you how stiff we can make the arm.

(Arm catalepsy is produced here.)

I'm going to start stroking it, and as I stroke it, the whole arm becomes stiff and heavy and rigid, just as heavy and stiff and firm as a board. As I stroke it, it'll get heavier and heavier and heavier. The muscles will stiffen. They will be just as stiff and rigid as a board. I'm going to count from one to five. When I reach the count of five, the arm will have stiffened up, just as stiff and heavy as a board. One, stiff; two, stiffer and stiffer; three, as stiff as a board, as stiff as a board, as stiff as a board; four, stiffer and stiffer and stiffer still; five, stiff, stiff. I'm going to let go, and when I let go, it'll remain stuck out in front of you, just as stiff as a board, just as stiff as a board, just as stiff as a board, just like that. Stiff, stiff, stiff. No matter how hard you try to bend it now, it'll remain stiff and rigid. It'll be just like a board.

It will not budge until I snap my finger. When I snap my finger, the arm will suddenly relax, and it will then be possible for you to bring the arm down to your thigh. I snap my finger. Now, it relaxes; it comes down; it comes down, just like that. And you go into an even deeper, deeper, more relaxed sleep. Breathe in deeply and go to sleep. Your breathing is becoming very deep now and very, very relaxed. Your breathing is deep and relaxed. And you're going into a deep, deep, relaxed, and comfortable sleep. When I talk to you next, you'll be more deeply asleep. You'll be more deeply asleep. Go to sleep now, and when I talk to you next, you will be more deeply asleep, more deeply asleep. *(Long pause.)*

I am going now to stroke the other arm, and, as I stroke it, it's

going to start feeling light, light, light, light; just as light as a feather. I'm going to count from one to five; at the count of five, it'll feel just like a feather. I'm going to grasp it by the wrist as I count. It'll float around in the breeze like a feather. One, light; two, lighter and lighter, just as light as a feather; three, as light as a feather, as light as a feather; four; five, just as light as a feather, floating around in the breeze, just like that. It will not come down; it will not come down. I'm going to let go now, and it's floating around in the breeze, floating around in the breeze.

(Arm is extended in the air.)

No matter how hard you try to bring it down, it remains straight up in the air, just like that; floating around in the breeze. It's going to stay there until I snap my fingers. When I snap my fingers, it'll slowly, but very slowly, come down. I'll show you. I snap my fingers, and it now slowly comes down, slowly down, slowly, just like that, just like that, straight down, straight down.

(Arm is down on thigh.)

And you go into a deeper, deeper, more relaxed sleep. Go to sleep now; go to sleep. *(Pause.)* Now listen carefully to me. I'm going to put a book in your hand. You're going to grasp the book in your hand, in your right hand. I'm going to ask you to grasp it very, very tightly.

(A book is placed in subject's hand.)

You're going to grasp it very, very tightly. Just let it hang this way, just like that. You grasp it very tightly. Your hands are closed down on the book. It's impossible now for you to drop the book. No matter how hard you try, your fingers are clamped on the book. It's glued to the book. You cannot let go; you cannot let go; you cannot let go, until I stroke your hand and remove the book, just like that. Your breathing gets deeper and more automatic, and, when I talk to you next, you will still be more deeply asleep, more deeply asleep, more deeply asleep. *(Pause.)*

Listen carefully to me. I'm going to take your hands and start revolving them, one around the other.

(This is for the purpose of inducing automatic movements.)

They'll begin revolving, one around the other. They'll revolve faster and faster and faster and faster, faster and faster and faster, just like that, just like a wheel. Around and around and around they go. When I let go, it will be impossible for you to stop rotating your hands. When

I let go, they'll keep going around faster and faster and faster. It's impossible to stop, it's impossible to stop, until I snap my fingers. When I snap my fingers, they'll suddenly stop, just like this.

(Fingers snap and revolutions cease.)

Now, bring them right down. You're going into a deeper and deeper and more relaxed, more comfortable sleep. When I talk to you next you'll be more deeply asleep, more deeply asleep. *(Pause.)*

Now listen carefully to me. I want you to bring your left hand right down on your thigh here, like this. I'm going to stroke it and it will be able to signal to me when I give you certain suggestions. By lifting a few inches, it will tell me you are responding positively. It'll be able to tell me when certain things are happening within you.

(This permits the subject to participate more actively and allows for time to elapse while inner adjustments are made to suggestions before they are accepted.)

For instance, I'd like to have you visualize yourself getting up out of the chair, walking through the door, going outside, and walking outdoors. As soon as you visualize yourself walking outdoors, I want you to indicate that to me by your hand, this hand, rising up just about six inches. It'll come up to about six inches, just as soon as you visualize yourself walking outdoors.

(Pause, and hand rises.)

Up it comes. Now bring it down, straight down to the thigh. Now, listen carefully to me. You walk outdoors, and you see an alleyway between two houses. You walk along this alleyway. You notice that on the side, on the right hand side, there is a pail of steaming hot water. You see the steam issue from the surface of the water, and you realize that the water is extremely hot. You wonder how hot the water actually is, so you take this hand, the right hand, this hand, and you plunge it right into the water.

(The purpose of these suggestions is to produce hyperesthesia.)

You notice that soon your hand begins to feel warm; it feels flushed. It may even begin to feel achey, and the muscles begin to contract; the skin begins to feel flushed. It may feel very, very tender, very, very tender, very tender and sensitive. I'm going to pinch it. When I pinch it, it will feel just as tender and sensitive as can be. I'm going to pinch it now.

(Hand is pinched and subject withdraws hand. The withdrawal reac-

tion indicates a susceptible subject. Absence of withdrawal is not too significant.)

You just draw your hand back. It feels very painful, very painful, just like that. I'll show you the difference in comparison with the other hand. Your other hand is insensitive. There's no real pain when I pinch it.

(Left hand is pinched.)

But this other hand is sensitive when I pinch it.

(Right hand is pinched.)

Sensitive, just like that. And you go into a deeper and deeper sleep.

(Pause.)

Now, imagine that you're wearing a glove, a heavy leather glove on your left hand. Imagine that you're wearing a glove, a heavy leather glove. As soon as you get the sensation of wearing a thick leather glove on your hand, a sort of dullness in your hand—as soon as you see your hand in your mind's eye with a heavy leather glove, indicate it to me by your hand rising up about a few inches. *(Pause.)* Your hand comes up; bring it down. Next, I want you to visualize yourself going into a doctor's office. You have a boil on your finger. You have a boil on your left finger. What I'm going to do is inject novocaine all around the wrist. When I put my finger around the wrist, it'll feel as if I'm injecting novocaine into the skin.

(Wrist is tapped with finger, circling it as if a novocaine block is being made. The purpose of these suggestions is to induce hand anesthesia.)

Your hand will soon begin to feel dull; your hand feels very, very dull, dull, dull. It is going to lose all sense of pain. In a moment I'm going to prick the hand with a pin, and you're going to notice how insensitive it is, how free of pain it is. I'm going to count from one to five. It gets dull, dull, dull. One, there's no pain, no pain; two, it gets duller and duller; three, there's no pain, there's no pain, there's no pain; four, no pain, no pain; five, no pain, no pain, no pain, no pain. I'm going to show you the difference between this hand here, the sensitive one on the right, and this hand here, the dull one on the left. I'm going to poke this right hand here with a pin, just like that, and it'll be very tender, even though I poke it very lightly.

(Hand is touched with a needle.)

But the other hand, even though I poke it deeply, there will be

no pain in it whatsoever, no pain in it whatsoever. When I poke it with a pin, you may feel a little pressure, but no real pain, even though I dig it in, just like that.

(Hand is touched with a needle.)

Do you notice the difference in the two hands?

(Subject nods.)

Yes, you do; good, good.

Now I'm going to stroke the hands again. I'm going to stroke both hands and normal sensations will return in them.

(Hands are stroked.)

You'll feel yourself getting drowsier and drowsier and drowsier. Go to sleep, deeply asleep; go to sleep, deeply asleep; go to sleep, deeply asleep; go to sleep, deeply asleep. You begin to feel yourself dozing off and going to sleep; drowsier and drowsier and drowsier. Your head has come over to the side of the chair now, just like that; and you're sitting there, deeply asleep, deeply asleep. You're getting very, very drowsy, drowsy, drowsy. Listen carefully to me. The next time we try this, you'll go to sleep very, very soon after I give you the suggestion to sleep. You'll go to sleep easily, with no effort, easily, with no effort. *(Pause.)*

You're going now to wake up. I'm going to wake you up in a minute or two. When you wake up, you'll notice an extremely interesting thing. It'll be practically impossible for you to keep your eyes open when you wake up. Your eyes will get heavier and heavier and heavier. They'll feel so heavy that they will want to shut; you may even begin dozing off until I snap my fingers, and then you will wake up completely. You'll be completely awake.

(The purpose here is to help convince the subject that she was actually drowsy as a result of the trance.)

In other words, I'm going to count now from one to five, and when I reach the count of five, you'll open your eyes. But even though you are awake, your eyes will be so heavy that it'll be almost impossible for you to keep your eyes open, or they'll feel heavy, very heavy, so that you'll find it uncomfortable to keep your eyes open. Your eyes may even close, or they may remain open, but they'll blink. But then, when I snap my fingers, you'll wake up completely; you'll wake up completely.

One, slowly start awakening, slowly start awakening, slowly start awakening; two, more and more; three, more and more still, more and

more still; four; five. Open your eyes now, open your eyes, open your eyes. You notice how heavy they feel; they blink; they want to close, they want to close, until I snap my fingers, and then you wake up completely. You wake up completely now; you wake up completely, just like that. Wake up, wake up.

(Subject is completely awake.)

Well, how do you feel?

S: I still feel a little sleepy.

DR.: Do you?

S: Yes.

DR.: Could you describe your feelings to me?

S: I feel as if I've been an awfully long way away.

DR.: Really?

S: Mm hmm.

DR.: What do you remember?

S: I think I . . . well, I . . . I . . . I think I remember what you said to me.

DR.: You remember practically everything?

S: I think so, yes, mm hmm.

DR.: Do you have any thoughts or any ideas that you'd like to discuss with me? You seem to have something on your mind.

S: I still feel sleepy.

DR.: You still feel sleepy?

S: Yes, I do.

DR.: Did you resent waking up?

S: *(Pause.)* Um, just a little.

DR.: Uh huh.

S: Mm hmm.

DR.: Your eyes are closing still.

S: Yes.

DR.: Well, you'll wake up in a moment; you'll wake up. In a moment you'll be completely awake. You'll feel relaxed.

(In most instances the drowsiness produced by the trance does not persist as it has here.)

S: Mm hmm.

DR.: Do you have a headache or any other sensation?

S: No, I just feel as if I could sleep for 48 hours.

DR.: Well, maybe—it may be—it may be a minute or two before you wake up completely. I think you'll make a fairly good subject. I think we probably will be able to train you to go into a very deep trance state.

S: That sounds wonderful.

DR.: Did you have an idea that you might be able to resist the suggestions? I mean, what was your reaction to the suggestions I gave you?

S: I felt at first that I wasn't hypnotized at all. And then I realized that I was.

DR.: What made you realize that?

S: I thought I could, uh, resist any suggestions that you made.

DR.: Yes.

S: But I found that I couldn't.

DR.: Did you actually try?

S: Yes, I really tried.

DR.: Well, now, most people feel when they come out of a trance they haven't been hypnotized; they feel they could have resisted suggestions. Now, actually that's true, they could have.

S: Yes.

DR.: But in a trance state they usually don't want to.

S: No.

DR.: And the feeling that one wasn't really asleep isn't far from wrong, because a person really isn't asleep. He just is in a mild state of relaxation in which he feels that suggestions have an effect in spite of himself. Can you tell me how you felt about your hand? Did you feel things happening in spite of yourself, or what?

S: Yes, I did, I did. When you . . . when you told me about my hand getting numb, I thought, well, now, that isn't going to really happen. And then, by Jove, I could feel it, just exactly like a shot of novocaine, and that tingling numbness that you get if you have a shot of novocaine, you know.

DR.: Mmhmm.

S: Then it seemed like a heavy leather glove, no sensation in it at all.

DR.: I see.

S: Really, it surprised me.

DR.: It did?

S: Yes, it did.

DR.: Good.

This terminates the first session with the subject. The following is the continuation of the interview with the physician for whose benefit the recording was played.

. . . DR. W: It's quite essential to prepare the patient adequately. You noticed that I sat down with the subject and I tried to get from her what she felt about hypnosis, trying to remove any misconceptions or fears or false ideas or false expectations that she might have.

DR. X: Mightn't it be a good idea, though, for a beginner like myself, to always use these preparatory exercises until I felt confident enough to proceed with straight hypnosis, when I could judge if the patient was prepared?

DR. W: Well, what preparatory exercises do you mean?

DR. X: Well, the swaying, the back-sway test and hand clasp.

DR. W: I believe so, yes. The hand clasp may work right into a trance as you noticed.

DR. X: I noticed that.

DR. W: A tip you may try is to clasp your own hands together as you talk. You get to feel the stiffness and the tightness of your own hand and you can communicate in your voice a conviction of tightness.

DR. X: Tell me, doctor, do you find that, by closely observing and following the development into trance of the patient, and adjusting your own speech rhythm and tone to that, that it keeps you more in touch with and in control of the patient?

DR. W: Oh, yes.

DR. X: I notice that in all these exercises you actually stimulated what might be going on in the patient's mind.

DR. W: Yes, I think it's quite important to follow the patient's reactions and to adjust the content of your talk to what he is doing. If the patient shifts in the chair, you say, "Now you've shifted in the chair." If the patient moves her head over, you comment on that. You say, "Now you've moved your head over to the side." This gives the patient an idea that what they are doing is following your suggestions.

DR. X: In other words, like any kind of practice, the more suggestions and the more actions that you can get the subject to do voluntarily or involuntarily, commenting on these helps persuade him to follow your suggestions?

DR. W: Yes. It is important to remember that if you have a rather authoritarian personality, you will do better with the more authoritarian approaches, like the first one of hand clasp. If you are a passive person, you will do much better with the technique of hypnosis through sleep suggestions, which sort of lulls the subject to sleep. If you want to work more actively with your patient, you'll do well with the technique of hand levitation, which is, as I said, one of the best methods. But the particular method is not too important. Whichever method works best for you is the method of choice. If you perfect one method and stick to it, you'll be able to get excellent results with that method. You don't really have to use all methods.

I want to discuss one more thing with you. Patients will usually tell you that they have not been hypnotized even if they have been in a good trance. This particular subject was an excellent one. Most subjects do not go to the point of hand anesthesia the first session. Most subjects will be able to go to hand hyperesthesia, but some may not even get to that point. If the subject fails to follow a certain suggestion, one may say to him: "Well, you cannot do it this time, but next time you'll probably be able to do it." And then he may be awakened. To get back to the other point, about the subject's statement that he wasn't hypnotized, one need not be concerned with this, since at a later session the subject may be challenged to open his eyes, and his inability to do it will usually convince him that he has been in a trance.

The following is a partial transcription of a recording made of a second conference with the same physician. It contains a discussion of the second session with the subject, which illustrates how hypnosis may be employed with psychotherapy.

. . . DR. W: In order to do therapy, you try to get the patient to enter as deep a trance as possible. Now, sometimes with no deeper trance than eye catalepsy and arm rigidity, it may be possible to proceed with hypnotherapy, but as a general rule you may have to go deeper than that.

DR. X: I see.

DR. W: So what you do is you proceed on beyond disorders in cutaneous sensibility, as I did in the session I played back to you, and get the person to a point where he shows an ability to talk in a trance without awakening, and where perhaps he may be able to respond to hallucinatory

suggestions. We may have an opportunity of demonstrating that a little later.

DR. X: Do you proceed with therapeutic suggestions right off, or are there tests by which you know when to proceed?

DR. W: You have to remember that the patient is going to have a definite reaction to the first trance induction. People respond to hypnosis in their own particular way, depending upon their own personal biases and problems. Some react with tremendous expectations that things are going to be done for them. Others develop reactions of fear; others respond with a need for detachment and a desire to run away from the situation, their neurotic defenses having been challenged. It is often essential to understand how the person has reacted to the first trance in order to proceed with the second. This is particularly the case where the person has been resistive toward the first induction attempt.

DR. X: Well, how would you—could you tell whether a person may have developed resistance?

DR. W: By listening to the verbalizations of the person explaining his attitudes toward the trance state or by observing his dreams, one may get clues regarding resistance.

DR. X: I see. Are the patient's reactions to the first trance an indication of how he will react to the second trance?

DR. W: Usually. However, some people will go into a deep trance the first time and then get frightened by it and refuse to go into a trance afterward.

DR. X: I see.

DR. W: In the latter case you try to analyze the reasons for this.

DR. X: You do that while in a trance, or do you question them about their reactions in the waking state?

DR. W: Both. (*Pause.*) I thought perhaps it might be useful to go on with the second trance session in the same voluntary subject to see if we could formulate certain principles out of that.

DR. X: I see. Do you do therapy in this, do you go into therapy in the second trance session, or do you have to induce hypnosis several times before the person is prepared enough?

DR. W: That depends entirely on what the problem is, how good a subject you have.

DR. X: Are there indications of that as you proceed?

DR. W: Yes.

DR. X: I see. Will you point those out?

DR. W: I shall be glad to. Now, what I'm going to do is play back a recording that I made of the second trance session in the same subject.

(The second trance session is played back.)

She went rapidly into a trance. What I did next was to train her to talk in a trance without awakening. Following this, I gave her hallucinatory suggestions of an auditory nature by suggesting that she hear bells in a churchyard, you remember? Following this, I induced olfactory hallucinations. Then I taught her how to fantasy. Now you notice that she wasn't able to see anything on the stage when I asked her to visualize a fearful scene.

DR. X: Why was that?

DR. W: The reason for that, I think, was that she was attempting to repress fearful aspects of her life, in much the same way that she's been attempting to run away from going to work. She's done this by repressing, by keeping away from it, by not tackling it.

DR. X: That doesn't necessarily invalidate or harm the therapy or your analysis?

DR. W: Oh, no. It does give me an idea as to what some of the basic problems are.

DR. X: I see.

DR. W: Actually, this was a therapeutic session. In trying to find out what was behind her work inhibition, it developed that what she really feared was jeopardizing her relations with people close to her, offending them by going out and getting a career. This seemed to be a carry-over of what she felt in very early childhood, a misconception or the actual realization that her sister did resent her success, that if she were successful and had a career, it would be resented.

DR. X: Yes, I see that.

DR. W: And the same thing possibly carried over with her previous husband. And now, with her present husband, she anticipates a similar situation. She seems to have gotten some insight into that. I think she'll probably be liberated from some of the anxiety that prevents her from going out and finding work.

DR. X: Do you continue suggestions until the patient reports effective relief?

DR. W: Well, now, actually she was trying to figure this out for herself. I didn't want to give her any suggestions. Perhaps I might have if we

adopted the approach of prestige suggestion, where I'd tell her authoritatively that she'd feel more confident in herself and that she would go out and tackle a job, where I'd attempt empirically to bolster her self-esteem. In this particular technique, what I did was to try to get her to see the reasons behind her fear of looking for work.

DR. X: And that is naturally more effective than the suggestive technique.

DR. W: Of course. Where it can be done, it's the only real way of getting at the core of the patient's problem. Right from this point on, the subsequent hypnotic sessions would follow along the same lines. In a trance state, we would utilize dream induction as a means of arriving at the basis of her problem. I wouldn't be a bit surprised if she were to get much more insight spontaneously now as time went along, and then finally crack the back of this problem.

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Group Psychotherapies

S. R. Slavson

A former president of the American Therapy Association, S. R. Slavson is a widely acknowledged authority in the field of group psychotherapy. He is director of group therapy at the Jewish Board of Guardians and is consultant to many service centers and bureaus. A former faculty member of the School of Education, New York University, and a frequent contributor to many educational and psychological journals, Mr. Slavson is also author or editor of the books *Analytic Group Psychotherapy*, *An Introduction to Group Psychotherapy*, and *The Practice of Group Therapy*.

Unlike most other psychotherapeutic techniques, which had their beginning in European countries, group psychotherapy originated in the United States. In the distant past, charlatans, medicine men, and miracle workers have probably affected cures in group work, but their techniques lacked the elements of planning, understanding, and control that characterize present-day group psychotherapy. In 1905, J. H. Pratt used what he called *class method* with a group of pulmonary-tuberculosis patients, and the changes in mental attitude were so impressive that the so-called "class method" was used in the treatment of other types of physical illness. Other workers quickly adapted the "class method" to groups of patients suffering from hypertension, peptic ulcers, and other illnesses. In the course of Slavson's own work, which began in 1934, the group technique has been applied to various types of mental disturbances in both children and adults. He has been especially successful in the application of psychoanalytic concepts to group therapy.

Slavson does not consider group therapy a substitute for other types of psychotherapy and believes it can be carried on properly only in an agency or clinic where psychiatric services are available. Although he believes that the ideal group should be composed of fewer than ten individuals, he recognizes the value of the group method in treating much larger groups when economy of time is important, as, for example, in wartime.

Group Psychotherapies

IN ANY consideration of group psychotherapy, it must be kept clearly in mind that group psychotherapy is primarily a clinical practice and as such must be based on sound therapeutic principles rather than on sociological or educational concepts. A therapy group is distinctly different from a social or recreational group. The dynamics of a therapy group differ in very important respects from those of natural or homogeneous groups of persons who gather together with a recreational or educational aim. In the latter the relationships are not charged with the same libidinal content and drives as the relationships in a therapy group, and social groups cannot permit the same type of activity or verbal release (catharsis) as that which is necessary for psychotherapy.

In ordinary groups the central person is the leader, who may be someone from the outside, professionally trained for this role, or one of the members of the group, that is, an endogenous leader. In the therapy group centrality is distributed, and all the members, including the therapist, come to the fore at various times during the group activities and interviews. When any one person in such a group holds precedence, the therapeutic process is either blocked or retarded. When this unbalance occurs, the burden of correcting it naturally falls upon the therapist during the interview itself. This makes the role of the therapist a difficult one and the therapeutic process of questionable effectiveness.

Although the therapist is the center of emotional cathexis, he does not act in a leadership role as the term is commonly understood. The members of therapy groups follow their own lines of interest,

which may have emotional meaning to them at any given time. There is no common or group plan, such as a program characteristic of the ordinary club or group. Each patient achieves catharsis and varying degrees of insight into his difficulties through his own effort and by means peculiar to himself. A therapy group is fluid, has little organization, and, to the casual observer, may appear to have no aim, direction, or purpose. But in a therapy group, all members have the *same*—but not a *common*—purpose. The purpose of each is to correct psychological distortions within himself, and each seeks his own improvement as a separate entity. There is no *group aim*.

In group therapy, as, indeed, in other types of groups, there are present the dynamics of interstimulation, interaction, induction, neutralization, identification, rivalry, and projection (14). The dynamics that appear only slightly or not at all are the integrative and the polarizing, which are the foundations of group formation (14). There is little cohesiveness in a therapy group; the patients throughout remain self-absorbed and preoccupied with their own problems. Seldom, if ever, does group cohesion emerge, and when it does, it is temporary. Nor can social stratifications and controls be countenanced in these groups. Because of the absence of homogeneity among the members, therapy groups can never become social groups.

In a properly balanced therapy group social, intellectual, and interest homogeneity and a common aim, which are the foundations for usual group formation and group cohesiveness, are absent. An ordinary group of individuals cannot permit the same degree of catharsis or the high density of hostility and aggression that characterize therapy groups. Therapy groups are and must be mobile in their organization, activities, and relations, in contrast with the comparatively fixed patterns that always emerge in ordinary groups. This latter characteristic, which is essential in ordinary clubs and groups, has been described as *social mobility*, as differentiated from *social fixity* (16).

It is rather important that the phenomena of the group should not be employed as an abstract construct or be given a metaphysical meaning. Groups will be best utilized in psychotherapy when their

dynamics and interpersonal relations are identified, described, and understood. The group cannot be considered as the subject of treatment, for the individuals are the patients—not the group as such. One of the paramount requisites for therapeutic results is, therefore, the therapist's continued awareness of the state and needs of each of the members of the group. The catalytic stimuli, as well as the other dynamics to be described here, support and facilitate therapy, but they are only means and not ends in themselves.

SUITABILITY OF PATIENTS FOR GROUP THERAPY

The above considerations make it evident that the proper choice of patients and proper grouping are at the very core of group psychotherapy. Not all patients can be treated together, and not all patients can respond to groups. In fact, some patients may be traumatized if exposed to the impact of such direct interaction with others.

No one method of psychotherapy can be regarded as universally applicable. The effectiveness of a method rests upon its suitable application to a given patient, and frequently several methods must be combined to effect good results. Perhaps the greatest skill of a therapist lies in his ability to understand the client's problem and to select the treatment to which the patient will best respond. When this matching of patient and treatment is accomplished, we can expect successful outcomes and certainly more rapid results than are possible when a treatment procedure is rigidly imposed. Individualization is the primary condition for successful work with people. It is also necessary for success in psychotherapy.

With very few exceptions, choice of patients for therapy groups follows the same lines as for individual psychotherapy. Generally speaking, patients who are inaccessible to treatment because of organic or constitutional defects, severity of problem, extreme regressive states, or excessive resistance to therapy may have to be excluded from groups as they may also be from individual treatment.

There are, however, a considerable number of patients whose resistances and defensiveness stem from a blind distrust, fear of competitiveness, and uncontrollable antagonism toward persons in power or authority. For such patients group treatment would be indicated as a preliminary to individual treatment and under certain specific conditions as exclusive treatment. In some regressive states patients are unable to establish a transference relation with an individual. On the other hand, there are also many patients for whom group therapy is contraindicated and who require individual psychotherapy or a thoroughgoing psychoanalysis.

In an extensive study of activity groups for children in latency, Helen M. Glauber found that

[one] method puts the chief responsibility for treatment upon group therapy with (psychiatric) casework mainly involved in manipulation of the environment and giving a supportive relationship. The children who benefit from this type of emphasis in treatment are the seriously distorted characters—borderline types—who can be helped by group therapy to test out the amount of aggression they have and to learn that some of their aggression is socially acceptable. At the same time, they are aided to build a socially acceptable front or defense against their inner pathological aggression

Another type of child who benefits from this (group) method is one who is arrested in his development due essentially to the lack of growth producing environment rather than severe emotional deprivations. These children blossom in a therapy group, plus environmental manipulation and supportive relationship with a caseworker on an infrequent basis. Many of them are eventually placed away from home

The third method of integration would place the major responsibility for treatment upon the caseworker. Group therapy in this instance is chiefly important as a testing ground for the patient's changing social attitudes

She further asserts:

Group therapy and casework (individual psychotherapy) can supplement, complement or completely displace each other depending upon the needs of the child. If the integration of these therapies is based

on a careful study and analysis of the child's personality in relation to his total life situation, the possibility for a successful therapeutic outcome is greatly enhanced (6).

The observations made by Glauber are, of course, also applicable to the treatment of adults and adolescents.

Criteria for selection of patients fall into two categories. The first includes such considerations as age range, sex, intellectual and social parity, need for substitutive sibling relations, negative or hostile attitudes toward siblings, inadequate social participation on the part of the patient in the past, destructive family-group relations that can be corrected through a more positive group experience, danger or fear of homosexual involvement with an individual therapist, character deviations, which are always better treated in groups, and readiness for group participation. The other group of criteria consists of clinical entities and diagnostic considerations. Patients who have anxiety and symptom neuroses, especially of the conversion type, those who have weak ego development, and those who have disorders such as infantile personalities and confused (sexual) identifications and ideological confusion are suitable for group treatment. Contraindications are psychopathy, narcissism, obsessional and compulsive states, hallucinations, and character neuroses.

Our present impression is that analytic (interview) groups are especially suitable for adolescent girls, even for those who have very serious emotional problems, provided that they are able to accept and participate in groups. An important consideration is the severity of the problem. Intense disturbances and strong and uncontrollable need to act out, either in behavior or in speech, render a patient unsuitable even in those categories that otherwise respond to group treatment. In such instances, because of these and other factors, a preliminary period of individual psychotherapy is required before assignment to a group.

COMPOSITION OF THE GROUP

In view of the fact that the total group atmosphere is set by the network of feelings among the members and the individual relationships, fitness of each member of the group is of major importance. Experience reveals that the presence of even one unsuitable patient in a group changes not only the content of the discussion but its entire atmosphere, and frequently the therapeutic process is completely interrupted and blocked by such a patient. It is less difficult to enumerate negative indications for grouping of patients than it is to suggest the positive. Indeed, much has to be left to the intuition and judgment of the person who groups patients—a judgment that becomes keener and more unerring with practice.

One of the chief aims of grouping is to prevent the density of pathology and aggression from rising above the limits of the patients' tolerance. Too many intensely disturbed persons who reinforce one another may create tensions that even the therapist may find it difficult to tolerate. Just as in activity groups, so in analytic groups some members should act as neutralizers, that is, persons who dilute emotional tensions and introduce the element of self-control. Acting out can become extremely disturbing if too many participate in it at the same time and if it occurs too frequently. Emotions such as rage, anger, distress, self-pity, and hopelessness are infectious. The aim should be to have enough variety in personalities (even though similar in their syndromes) and problems to prevent too great reinforcement and overintensification.

Patients are well suited for interview psychotherapy together if they act so as to catalyze one another. To do this, (1) there must be adequate feeling of similarity of problems (identification); (2) some of the members must be less conflicted and less shy than others; (3) they must help one another decrease anxiety (through neutralization); and (4) they must act to diminish the homoerotic drives toward one another.

DYNAMIC FACTORS IN ANALYTIC GROUP THERAPY

Since group therapy is a clinical technique, it must be based upon dynamics common to all psychotherapy. These are *relationship, catharsis, insight, ego strengthening, reality testing, and sublimation*.

Successful psychotherapy is based upon a fundamental positive relationship between the patient and the therapist and, in the case of group psychotherapy, between the patient and the other members of the group. It is commonly conceded that the foundation of all psychotherapy is relationship, which may be of the transference type described by Freud or one of those of lesser intensity that are commonly encountered in psychotherapy. In groups, however, one is often concerned with more than one type of relationship, since there may also be unilateral, bilateral, multilateral, anaclitic, or domination-submission relationships (17).

When the basic transference is positive, catharsis can take place, and the patient can regress to the levels of early fixations. He is able either to talk about his infantile wishes and fantasies or to act them out in the group because of the assurance that the therapist and the group members are nonjudgmental and nonpunitive. Each member of the group is unafraid to reveal the material that he so carefully repressed or attempted to disguise. When favorable conditions exist, patients regress in a group with greater ease and rapidity than in individual therapy. The regressive process is aided in part by the support that the members receive from one another in their hostility toward the therapist (negative transference).

The regressive effect of the group is a great advantage in therapy, for, as is well known, emotional growth of the patient is aided when regression to the stage of early fixation takes place and the conditions favor growth from this point. Through the support and help of the therapist and fellow patients, each is able to evolve toward a level more consistent with his chronological maturity. All

who have worked with analytic therapy groups have found that the productivity of patients in such groups is greatly accelerated. Patients reveal themselves much more readily and frequently go deeper into some of their problems than they otherwise could. Resistance is decidedly diminished in groups through the support and approval that the members give one another.

As in all other methods of psychotherapy, transferences in groups are fundamental and transitory. The fundamental transference must be positive if psychotherapy is to occur, but the patient's temporary periods of hostility, dislike, or fear of the therapist are inevitable as well as essential. These are the transitory phases of the transference. The patient must accept the therapist and trust and admire him, even though occasionally he may feel antagonistic toward him. He must also feel sufficiently comfortable in the relationship with the other group members, or catharsis will be blocked. Patients who are unable to establish such positive feelings or who feel too threatened by a group usually discontinue therapy in the group. Frequently negative feelings toward the group therapist are held in check because of fear of retaliation on the part of the others, who may have positive feelings and loyalty to the therapist, and aggression may be displaced and redirected toward fellow group members. This is the mechanism of *target multiplicity*, which also helps to accelerate catharsis because redirecting hostility away from the therapist serves to reduce anxiety. In analytic groups it is essential, however, that patients eventually express their hostile feelings toward the therapist. Since he is a parent surrogate, the original hostility toward parents must find expression in attitudes toward him. It is not enough to discharge this hostility against other members of the group, who are for the most part sibling substitutes.

Transference in therapy groups is considerably modified by the presence of more than one patient. In individual treatment, transference is concentrated on the therapist alone, but in group therapy early feelings toward siblings are clearly revealed and acted out in relationships arising among the various members of the group. Rival-

ries, jealousies, hostilities, and drives to dominance and submission are evident here, as they are in natural families. These we term *sibling transferences*, which are possible in groups because the therapist is not the sole focus of cathexis; the various members of the group are also recipients of affection and hostility. At the same time there is considerable identification among the members of groups, a fact that proves very beneficial to the total group atmosphere and the therapeutic process. This can be described as *identification transference*.

Dilution of transference is a common and inevitable occurrence in groups in which both sibling transferences and identification transferences are major forces. This phenomenon also involves another dynamic that operates in groups to facilitate the treatment process. This is *cathexis displacement*. The cathexis which in individual treatment is directed only toward the therapist can be displaced upon other persons in the group, and this, too, tends to dilute the transference. We have found, however, that cathexis displacement extends also to the patients' relations with parents, siblings, mates, and other persons of importance. Cathexis displacement is inherent in the transference relation in which the therapist becomes the center of the patient's affect. Any method that aids or accelerates cathexis displacement helps set the conditions for emotional change. From what patients have said and through other means of communication we have found that the group as a whole and fellow patients as individuals become important to the life of each member of the group. Among the means by which this concern is communicated are direct expressions of enthusiasm and need for the group sessions, consistent attendance, and loyalty as well as antagonism, all of which demonstrate that the group becomes an emotional focal point. Concomitant with this development are a decrease in the frequency of the patients' mention of their parents, siblings, and mates and a lessened emotionality in relation to these persons. It would seem that these persons are no longer so meaningful or important as formerly, clearly indicating emotional maturation as the patients are weaned from their

earlier dependencies. In some instances there is also a diminution of ego defenses, which can occur only when substitute sources of satisfaction are offered to take the place of earlier ones.

Anything that becomes emotionally significant to the patient, such as a therapy group, for example, can also become a focus of intense emotionality and cathexis. The individual can receive from the group the satisfactions and security that he originally sought from his parents. Thus, the group serves *in loco maternis*, but in transferring the accompanying feelings from the natural mother to the group, a "separation" from the former takes place, which in many instances has been greatly delayed. Because of his emotional immaturity, the patient cannot give up his earlier ties without a substitute love object. In individual psychotherapy this object is the therapist; in group psychotherapy it may be any one of the members or the group as a whole.

Members of therapy groups are preoccupied with unresolved infantile cravings, hostile feelings, and destructive drives, with which a great deal of anxiety is associated. In group psychotherapy, however, the anxiety seldom mounts to the level of intensity that it reaches in individual treatment, since dilution of transference and universalization tend to diminish anxiety. This decrease in tension is achieved partly by *displacement* of negative feelings toward other members of the group and away from the therapist and partly by the fact that each member feels that he is not alone in his drives and cravings. The onus and guilt associated with the neurotic's hostile impulses are diminished by the discovery that others as well have such impulses, a process described as *universalization*, and as a result the superego demands are less justified and real. The defenses that the neurotic has built up yield more readily when sanction and support from other persons are forthcoming.

Universalization is aided as well by interpatient therapy. A great deal of interpretation of unconscious material, including dreams, is given by patients to one another; thus they share some of their innermost and well-guarded secrets. Very frequently deep interpretation cannot be undertaken by a therapist because of the threat to

the patient's defenses. But the striking fact that patients in groups accept from each other interpretations of a nature and depth that they would not accept from a therapist has been observed.

The *support* that patients give one another in this connection is important. The unconscious and deeply repressed fear of rejection and punishment by the therapist as a parent figure is allayed by the awareness on the part of each patient that he is not alone in such feelings. The psychological effect of the realization that other members of the group share these feelings constitutes group sanction from the viewpoint of the individual. Groups also offer opportunities for patients with weak egos to *act out* anger, hostility, disgust, and revulsion. This also tends to decrease intrapsychic tensions, since avenues are provided for expressing aggression through neuromuscular channels.

Although the total effect of the group is a tendency to diminish anxiety and thus aid in catharsis, there is an inherent disadvantage in the fact that the deeper levels of personality are not reached in group psychotherapy. The escape from mounting anxiety, which is provided by displacement, deflection, and withdrawal, along with the dilution mechanisms already described, relieves the patient of the necessity to explore the deeper realms and prevents the development of insight to the degree that is possible in individual treatment. Although the group therapist helps each patient to free himself from his infantile fixations and to better understand his reactions and some of the causes of his psychological stress and social maladjustments, the therapist can accomplish this only to the degree that diluted transference and the other members of the group will permit. Thus, one is forced to the conclusion that a full-blown neurosis with intense involvements can be treated only by a thoroughgoing psychoanalysis.

It has been found that fellow patients take over the role of the therapist and pursue the investigation and elaboration of problems beyond the point that would be safe or advisable for the therapist in a group or even in individual treatment. Here, again, the sibling transferences are less threatening than is the transference to the

therapist. Insight may occur as a result of individuals within the group identifying with each other. As a patient identifies with another who reveals conflicts and difficulties similar to his own, he is able to objectify his inner preoccupations through the resulting *vicarious catharsis* and identification therapy. But free association by a patient may also create anxiety and even panic in others who are not ready to face the problem as revealed. Here, the therapist has to neutralize the emotional tension and prevent the mounting of anxiety to a level too great for some of the patients to bear. He may have to see some of them individually immediately after the group session.

Just as the lessening of anxiety limits the intensity of the therapy in a group, the check that it imposes on insight is also a limiting factor. Even where the patient fully trusts the therapist, fear of other members prevents some of the more conflicted and shy from revealing themselves. The therapist, too, when giving interpretation, needs to beware of unmasking a patient before the group beyond a point that the patient can accept. It is preferable that interpretation come from other members of the group, and this constantly occurs as patients respond to the unconscious needs of one another through identification and empathy. They help one another attain insight by establishing the connection between behavior and motives.

Strengthening of the ego is achieved in group psychotherapy, as in other types of treatment, from the fact that the ego energies are freed from the task of keeping in repression unpleasant impulses, thoughts, and strivings and become available for dealing more adequately with inner and outer reality. As long as the ego has the task of holding in repression anxiety-evoking and guilt-producing feelings, its energies are bound down and are unavailable for other more constructive and socially acceptable functions. Another effect of psychotherapy, and especially of group psychotherapy, is that through universalization, support, and identification, the quantum of guilt is diminished, and the ego, through utilization of the various systems of defenses that it has evolved, is in a better position to cope with

guilt feelings. This further frees ego energies for emotional growth and realignment of the psychical forces of the individual.

Much guilt and anxiety develop in patients from prohibited libidinal strivings that have been inadequately repressed and that seek gratification. As a result of both cathexis displacement and the bringing out of these infantile strivings into conscious recognition through catharsis and insight, the patient is freed from these urges. Here, again, the ego energies are further enhanced as the ego is relieved from the not too successful task of holding them down.

Ego strengths are also derived in therapy groups from the changed self-image. Perception of the self as a more successful, more acceptable, and more worth-while person emerges from a number of situations that occur in these groups. One is accepted by others as a worthy person; his opinions receive attention and are discussed seriously by others; others are interested in one and seriously try to help; one is accepted by a group (siblings) and a therapist (parent figure) as worthy of attention and consideration. The awareness of growing strength to deal adequately with formerly distressing problems and uncontrollable impulses gives a further boost to the self-image and makes the patient feel more adequate and more at peace. This and other changes in attitudes toward self and in feelings of self-esteem result in a strengthened ego organization that requires less reliance upon one's usually ineffectual ego defenses.

Another factor in the therapeutic process is reality testing. It is commonly recognized that psychotherapy does not occur in a vacuum, nor is it limited entirely to the relation of the therapist and the patient. Patients in individual treatment and in hospitals and institutions constantly test themselves against the reality of everyday living. Living and therapy go hand in hand. If a patient were to be isolated from every contact of the world and put under treatment by the most skilled of therapists, he would not improve. Improvement comes only through the dynamic interaction with human environment. Man is nothing without the work of man, and that which is human is given us by other humans. All emotional and mental

difficulties that do not have constitutional or organic roots arise from disturbances in interpersonal relations, and their correction as well can be achieved through these relations. Hence, a plan of treatment must always take into consideration *the living situation of the patient*. This living situation may be his own setting of family, friends, and colleagues, or it may be a specially conditioned environment, such as a hospital or institution, or it may consist of the relations that ensue from the group therapeutic situation.

Whatever the setting, improvement is well nigh impossible without the element of reality. In this respect group psychotherapy is vastly advantageous over individual treatment. The group is a genuine, tangible reality, for here the patient faces other people and responds to them to the extent of his abilities. He makes adjustments to the network of emotions, pressures, and tensions that inevitably arise in a group. He finds an impelling need to modify his impulses, thoughts, and attitudes in order to become a part of it. He evolves aims for himself and establishes relationships on the basis of preferences, sympathies, and antipathies. Group psychotherapy thus supplies each patient with a selective environment with which he can deal in part or as a whole.

That the constitution of the group has to be planned in advance is both an advantage and a limiting factor. The advantages lie in the fact that pressures and complexities of reality can be controlled; at the same time, however, the reality is both attenuated and more or less artificial. Despite this, there are patients who cannot possibly face group demands, no matter how slight, nor enter into multiple relations, and such patients should not be exposed to the strain of group interactions. Therapy groups present emotional reality of a high degree of intensity. Feelings run high and conflicts, recrimination, and discord are at times difficult to prevent or escape. The therapist must be on the alert to prevent the onset of overintense anxiety and guilt.

A further element in psychotherapy is sublimation. The function of sublimation is to redirect instinctive drives into channels that are acceptable to the ego and to society and its mores. It is an

alternative to the repression of the original impulses and cravings of the id (instincts) and, therefore, is important in maintaining health and equilibrium of the psyche. The difficulty that the neurotic experiences is due to the presence of unsuccessful repressions on the one hand and an overdeveloped superego on the other, a situation in which he can neither express nor sublimate these instinctual drives. They are rather in a state of conflict with the censoring and inhibitive forces and thus are not permitted to be canalized into acceptable expression of aim-fulfillment. The reason why young children sublimate their drives with ease in games and activities is that their impulses have not as yet been repressed into the unconscious or have been only partly repressed. Acting out, therefore, does not create conflict or arouse guilt. The child finds channels of sublimation in such desexualized activities as playing with clay, water, paints, or fire, in hunting and killing insects, in sliding down banisters, and in the numerous other play and creative activities that supply him with outlets. Instead of actually acting out anal aggressions and anal fixations, the child uses clay or does finger painting. When he gets angry, instead of attacking the people around him, he may play at firing toy guns at random or perhaps at some person, who may or may not be the real object of his aggression.

These are acceptable forms of sublimation and displacement, and psychotherapy should supply them, especially for young children. As the child finds satisfactory sublimations for aggressive drives and more mature patterns for aim gratification, his ego is strengthened by its release from the function of maintaining control over primitive impulses. One of the chief values of activity group therapy is that it always has opportunities for sublimation ready at hand. One of the criteria for accepting patients for group therapy is their capacity to use sublimatory opportunities for the discharge of primary drives. This condition limits acceptance to certain types of patients.

To the other advantages of group therapy there needs to be added the fact that by their very nature and constitution groups supply opportunities for sublimation that are seldom found in other types of psychotherapy. The group provides the motivation for expressing

oneself in a manner approved by the other members. Opportunities for sublimatory activities are among the main values of occupational and recreational therapy. Interview groups for adolescents and adults as such, however, do not offer many outlets in this direction, although they can release and motivate the patient to seek such outlets in the setting of his environment. In a good institution or hospital, sublimatory activities are ready at hand, and patients are helped to discover and establish interests that redirect their psychic energies into constructive channels.

GROUP THERAPY WITH CHILDREN

We have reversed the usual order of describing group psychotherapy by first discussing the type that is employed with adolescents and adults, namely, analytic (interview) group psychotherapy, rather than the activity types that are employed with children. In a real sense group psychotherapy is most effective and most suitable in work with children because free group relations are much more appropriate to children than they are to adults. However, the reversal of presentation was deemed advisable because of the fact that the major preoccupation of the average psychotherapist is with adults. For a number of sociological and economic reasons, there are comparatively few psychotherapists who work primarily with children. Group psychotherapy, however, is applicable to the majority of children with problems, but it has considerably less application to patients in the postpubertal stage of development.

Work with children includes four distinct types of groups evolved by the present writer and employed according to the specific needs, as well as the specific clinical categories, found among the children.

Activity-Group Therapy

The first of these techniques employed with children and the earliest that we attempted (in 1934) is now known as *activity-*

group therapy. In this procedure the children are exposed to an environment that is accessible in every respect, one in which they can feel free to act out their impulses, hostilities, and fantasies, even to the point of committing aggressive acts directed against the person of the therapist. The setting for such groups is always very simple. The furniture is made of ordinary planks and is especially designed for rough handling. The materials supplied are mostly those with which children are already acquainted through school or other experiences in everyday life and include such simple things as hammers, saws, wood of various sizes, clay, water colors, copper and pewter disks, appropriate molds for making ashtrays, and large sheets of paper. There is also equipment for the cooking of simple refreshments. The room is large enough for the children to be able to move around freely and not get in each other's way, but not so large as to invite running around and the use of the room as a playfield.

After an hour or an hour and a half of activities, which ordinarily consist of a considerable amount of free play, hilarity, and aggressiveness, as well as constructive work, a half-hour to forty minutes is devoted to taking refreshments together as a group. These refreshments are sometimes brought in; at other times simple food, such as canned soup, frankfurters, or hot chocolate, is cooked on the electric stove that is part of the equipment.

The role of the therapist is what we describe as a *neutral* one, by which we mean that he does not assume any specific role. He neither prohibits nor condones; he imposes neither restrictions nor rules and does not mete out approval or disapproval; he is neither an observer nor an active participant. As the children request help or supplies, he meets these needs. From the history submitted to him, the therapist is aware of each child's background, constitution, and difficulties, and he manages to meet the patients' conscious and unconscious needs in an unobtrusive and subtle manner. Thus, he would support a weak, frightened child by taking a position near him, or he would indicate his approval or nonacceptance of behavior by another child by averting his eyes or not looking at what is occurring around him. The therapist sees to it that the children have the supplies at hand

as they need them and that their creative impulses are met by the necessary materials. He also gets the food. He takes the children on trips when they are ready for it as a means of expanding their environment and helping them become acquainted with the city or town in which they live. This expansion of the physical and social reality serves to strengthen the child's ego and develop what is commonly known as courage and skills to deal with the environment.

This type of therapy aims to provide the discharge of inner pressures and tensions resulting from the inhibitions to which the children have been exposed in the past. It gives them a feeling of being accepted and worthy, despite their behavior deviations, and convinces them of their acceptability as people by virtue of the fact that the therapist accepts them. The situation and the pressure of the group itself helps to control impulses and behavior, which, in turn, results in the strengthening of the ego. This therapy also provides the child with direct experience with reality on his own terms and evolves a new comprehension and concept of reality, both in the physical setting and in relation to others. The opportunity is found here to develop relationships in a free environment and on the terms of the patient as he becomes ready for it.

Since most of the children who come for treatment have previously experienced only basic hostility and rejection, this type of therapy convinces the child for the first time of the existence of positive and constructive attitudes in adults. It also provides the children with substitute gratifications for the deprivations to which they have been exposed in the past. Further, this type of therapy integrates the psychic forces that function in diverse and sometimes contradictory and conflicting directions and interfere with aim gratifications as the child attempts to conform with both social requirements and personal advantage. It is clear that an integrated totality can be attained only from the experiencing of an appropriate and corrective living situation acceptable to the child and a constructive relationship with an adult. Only in these circumstances would the child alter the attitudes and feelings engendered in him in the past by unfriendly and frustrating adults.

Transference

The basic dynamics of *transference*, *catharsis*, *insight*, *ego strengthening*, *reality testing* and *sublimation* are operative in this type of treatment as they are in others. All psychotherapy seems to be based on the same dynamics, although they may be modified to some degree and in some directions. In activity-group therapy transference, for example, is not as distinctive as it is in other types of therapy. Although we have observed that every child definitely acts out early patterns in the family, the libidinal aspect of the transference observed in other types of therapy, especially the analytic kind, is not present here. Because the therapist is a comparatively neutral individual without a specific role in the libidinal economy of the child, he does not activate libidinal elements of the transference relation. However, as in other therapies, the attitude toward the therapist must be basically a positive one; otherwise, the destructive acting out is of such intensity that no therapeutic results for the group members are possible.

We have found that whenever the therapist is unsuitable for a group, hostile or playful aggressions are so frequent and intense as to make reintegration of the psychic forces of the children impossible. It is expected here (as in other types of psychotherapy) that periods of negative transference (hostility and aggression toward the therapist) will appear, but the basic transference, as differentiated from one of a transitory nature, must be positive. The fact that the therapist accepts all types of behavior without retaliation, punishment, or the arousing of guilt favors the emergence of positive feelings toward him.

Transference among the children must also be predominantly positive. Experience shows that whenever there is a fundamental negativism among members of these groups, acting out of hostility and recrimination, quarreling and fighting become prevalent. This not only disturbs the patients involved in the struggle but steps up fear and anxiety in the others, who may, as a result, stop coming to the group sessions.

The low quantum of sexuality in the transference among the children in these groups does not mean that the sexual factor is entirely absent. There are a considerable number of direct and indirect manifestations of sexual interests and preoccupations, both in play and in constructive work. Sometimes there are direct sexual attacks, such as grabbing of genitals, touching each other, straddling one another, rolling on the floor, or going to the toilet together. Nonetheless, the transference here is less charged with the drives and colorings that one observes in the other types of psychotherapies, owing in part to the fact that only children in the age of latency are included in these groups. Activity group psychotherapy is suitable only for children between the ages of seven and twelve, and segregation of boys and girls is necessary.

Catharsis

Catharsis here, as already indicated, consists in free acting out of drives, anxieties, and fantasies. This is done both in isolated and in group play, as well as through manual occupations. Occasionally there is communication on the part of the children of their attitudes, feelings, and relations (verbal catharsis), but this occurs only infrequently in this type of group. Because of the choice of members for these groups in whom the psychoneurotic constellations are not definite or intense, verbalization does not play so important a role as in the interview type of group therapy. Whenever patients present serious disturbances, they are referred either to individual treatment or to the interview type of group.

Insight

Insight, as we understand it psychotherapeutically, occurs to a minimum degree in these groups because the therapist does not interpret the conversations and behavior of the children. Insight of a subjective nature is not evoked or encouraged. However, we have found quite a number of children in our groups who have become aware of the changes in themselves and their relationships to others. Because this insight is not evoked or activated by the therapist but

rather is derived from the child's own experience and inner awareness, we refer to it as *derivative insight*, in contrast with the direct insight in other types of psychotherapy.

Ego Strengthening

Ego strengthening is probably the greatest contribution of this type of therapy. The entire setting of these groups, the relationships and the activity, is designed to strengthen the child's ego. By this we mean that the total experience results in the child's increased ability to deal with his impulses and outer reality (or actuality). His ego is strengthened by virtue of the fact that he has been helped by the other members of the group to control his drives and regulate expression of feelings. Also, he no longer considers the demands of social reality as an invasion of his narcissistic and egotistical patterns. This integration of the psychic forces and their efficient utilization result from the adaptations demanded by the others in the group and the imposition of the group climate.

Reality Testing

In the area of reality testing, the activity therapy group is of utmost and incomparable importance in the treatment of young children. The demands that have been imposed upon the children who come for treatment are either overmature and too difficult or inadequate to mobilize their ego strengths. In some instances these demands for a high level of function and achievement, such as in school or in adaptation to siblings, parents, other members of the family, and persons outside of it, have been imposed with too great a threat and too abruptly, arbitrarily, and even cruelly. These have become a source of restraint or frustration, or of both. In activity therapy groups the reality of the situation is an attenuated one. At first, the situation is one of complete permissiveness, such as is required by an infant, for we consider the children who come to us as infants psychologically, even though they may be older chronologically. Gradually the group situation becomes more restraining and more demanding both through the interaction of the children with

one another and through the slowly evolving group code and the changing role of the therapist. All these aid in the development of a more realistic type of adaptation in conformity with the maturing powers of the individual. In cases where the child has been pampered and overprotected, the group situation imposes upon him the need for self-reliance and self-assertion.

There is evident a genuine desire on the part of each child to adapt himself to the new reality, largely because of its pleasurable nature and the satisfactions that accrue from it. He knows quite well that overstepping and transgressing too many of the necessary controls would make him unacceptable to the group and that he would then be rejected by the other children. In choosing our patients for these groups, therefore, we choose them because they have a deep-rooted desire to be accepted by other children and to be a part of a group. This we refer to as *social hunger*. Social hunger is the motive for the child's coming to the group in the first place, for bringing himself under control, or, as the case may be, for asserting himself more in order to belong to the group. Once the child has experienced acceptance, he discovers the pleasure-yielding effect of self-control and self-inhibition. He discovers that he can enjoy many advantages of relationships and pleasurable activity if he fits into a group. There is also the motivation of satisfying the "good" adult, the therapist, because of his kindness and his accepting and permissive attitude. These realities, though having their roots in the pleasure drive, become strongly entrenched in the psyche of the child, and the perception that reality is frustrating, punitive, and restraining gradually disappears. These newly discovered attitudes are then transferred to other relationships, such as those in school, with playmates, and in the home.

Sublimation

It is apparent that the materials, the opportunities for free play, the use of colors, banging with hammers, playing with guns, and throwing things about are means for displacement of ag-

gression and sublimation of hostile drives. Displacement precedes sublimation. Children first attack the environment, sometimes quite violently. They may scratch the paint off or put paint on the walls, dislodge plaster from the walls, throw small objects at passers-by, start small fires, throw paints and water about, and generally damage the room. This we understand as displacement of hostilities, the displacement being from adults who have frustrated them to the therapist. But since the therapist, because of his neutral, passive, permissive, and positive attitudes, does not evoke direct aggression against himself, the children displace it upon that which represents the therapist, namely, the physical environment. Soon, however, under the influence of the more constructive and better organized members in the group (neutralizers) and by the natural running down of aggressiveness (release), the children take up sublimatory activities, such as hammering out ashtrays, cutting and hammering wood, painting pictures, working with clay, burning with an electric stylus, and similar forms of sublimation of both sexual and nonsexual drives.

The choice of patients for these groups is, of course, of greatest importance. Obviously, children who have no social hunger and no inner capacity for bringing themselves under control are unsuitable for this type of therapy. It is therefore necessary to exclude psychotics (except mild schizophrenic personalities), psychopathic personalities, extreme behavior disorders (especially of the pre-Oedipal type), neurotic characters, and children with extreme sibling rivalry. In other words, children are excluded who approach (as a limit) the psychopathic personality; that is, those in whom the ego structure is very weak, the superego is defective, and there have been inadequate primary relationships during infancy and childhood with some constructive adult—parents or such substitute parents as a nurse, grandparents, or other relatives. The absence of these positive, primary relationships in the earliest years of the child's life makes him either a poor risk or unsuitable for this type of psychotherapy because of a lack of a self-regulative power in his psychic organization. Extreme sibling rivalry also makes it difficult, and sometimes quite

impossible, for children to fit into these groups. We usually recommend a period of individual play therapy in which the child can clarify his attitudes toward his siblings and evolve some modicum of control over his feelings.

The most suitable children for these groups are the pre-Oedipal primary behavior disorders of a mild type; primary behavior disorders of the Oedipal type; mild neurotic reactions, that is, those in which there are no real psychoneurotic constellations with extreme fears, phobias, anxieties, and compulsions, although some compulsive traits have been found to be benefited by activity group therapy; character disorders that are the result of faulty identifications, such as a boy identifying with a sister or mother or one who lacks identification with a constructive father figure; infantilized children; only children who have no experience with sibling relationships and sharing with others; mild schizophrenic characters in remission, although these must be placed in very mild groups that will not threaten or frighten them in any way; and some forms of not too intensive schizoid personalities. All these can be placed in activity therapy groups.

In the grouping of children there must always be a sufficient spread of behavioral types, such as aggressives, comparatively normal children, and the neutral or withdrawn type. The aggressives we term *instigators*; the fairly well organized children are termed *neutralizers*; and the others are *neuters*. There should also be included in these groups some *isolates* who are unable to participate with the others, but not because of a serious psychic trauma or serious constitutional or psychotic primary withdrawal. Too many aggressives, or instigators, cannot be tolerated in these groups because too much hyperactivity is generated (nodal behavior), which disturbs the group atmosphere to such a degree that no therapeutic effect can be obtained. The absence of instigators, on the other hand, makes the group an ordinary shop group without the emotional interaction and stirring up that are required in order to strengthen the ego. The ego cannot grow and exercise when the groups are quiet, peaceful, and overly constructive.

There is no specific limit to the number of neutralizers, although

too many social neuters who do not participate in the group activities may be detrimental. It has been found that neuters soon become active to varying degrees and that isolates often become so released as to grow aggressive for a period during their transition to more normal social adaptation.

There is considerable fluidity in relationships in these groups, but the outstanding relationship pattern is one that we call *supportive ego*. We observed that most children in activity groups select specific individuals whom they need as supports during the early periods of membership; they pair off and retain a more or less enduring relationship with each other for a period of time. We have also observed that the supportive ego function is a temporary one, for a child usually changes his supportive ego as he becomes more self-reliant, choosing either a stronger or a less active child for that role. This choice reflects his need at any given time. As treatment proceeds and the child becomes stronger and more self-reliant, he drops the supportive ego relationships altogether and functions on his own as a *free-floating member* of the group. This means that he is now sufficiently individualized, that his self-image has improved, and that his ego has been strengthened sufficiently for him to conduct himself without help from another person. This development is a definite indication of improvement in the psychic organization of the patient.

As we said earlier, therapy groups never become clubs in the ordinary sense of the word, and efforts at forming them into clubs have always failed. The unifying principle, the common purpose or aim, and the cohesiveness characteristic of homogeneous groups and other associations is never present in therapy groups. The reason is that the children are not chosen because of any factor of homogeneity that would cement them and beget a sharing of interests, ideas, or aims; rather, they are chosen because of individual problems. The factor of homogeneity and centrality that is important for forming social and interest groups and clubs is absent.

In activity groups, the plan for grouping that was finally evolved consists of grouping children in accordance with the therapeutic effect that they may have upon one another. Thus, children who are

somewhat aggressive are grouped with children who are inclined toward withdrawal, and infantile children—those who act out their childish impulses—are exposed to the influence of more mature co-members. The withdrawn child is drawn in by the more outgoing members of the group into play and activity and is thereby able to overcome initial fears of his impulses and to find courage to discharge his repressed hostilities and resentment. On the other hand, the aggressive child is regulated in the expression of his aggressiveness by the stronger but less aggressive individuals. Thus, a balance in a group results, and as the children continue to adapt themselves, the group evolves into one with normal pressures and desirable relationships. The self-indulgent, narcissistic, infantile children, who in a number of cases are only children in their families, are provided with the restraints that come from others who have made more mature adaptations. The latter impress the self-indulgent members with the fact that they cannot exploit others for their own personal gratifications without meeting the requirements that the group imposes.

Among the factors that operate in the group to help the maturing of the personality of the child and readaptation to more normal responses is the fact that a wholesome replica of family relationships is provided in these groups. All the children who are chosen for group treatment are those who, for varying reasons, have had undesirable or destructive relationships in the family with either parents or siblings. The atmosphere of the group is such that it tends to correct the earlier negative attitudes—destructive feelings and fears and insecurities in a family relation. The group approaches the ideal family life as closely as it is possible to do so in practice. The group therapist represents to the child a positive, constructive parent figure, who, while accepting his current personality, does not necessarily accept his destructive behavior.

Many of our boys in particular feel themselves sexually inadequate because of the adaptations they were forced to make in early childhood to overpowering women in their families or because of identification with weak and inadequate fathers or because of the absence of males in the family. The reaction to such feelings of

sexual inadequacy results in either excessive compliance and meekness or an exaggerated, reactive, bullying type of behavior. For such children these groups have special value. When a life experience, such as that which the group provides, allows adaptations to other boys and identification with a strong, secure male in the person of the worker, the boy develops the capacity for expressing the normal aggression and domination that is associated with maleness. Being in close contact with boys who freely act out such aggression has an inestimable corrective value for each member of the group who has the problem of sexual inadequacy.

To summarize: The plan of activity group therapy is to provide for children opportunities for satisfying occupations on a creative level as well as exposure to relationships of a corrective nature. The work of those who are not so skilled is accepted and praised by the therapist with the same enthusiasm as the objects of art created by their more skillful associates. Thus, every form of competitiveness, standard of performance, and comparison is eliminated, so that each child feels himself fully accepted for what he is worth by the therapist and his fellow members.

In addition to bringing about social adaptations, activity therapy groups have the effect of releasing the child's pent-up energy through constructive work. The child's attitude toward himself as a person (self-image) is greatly improved, and as a consequence he becomes more accepting of others in his immediate environment. The total experience in such groups results in a more mature personality structure and an increased capacity to deal with reality.

Transitional-Group Therapy

Another type of therapy group employed during the period of latency and in the age of puberty is *transitional-group therapy*. This is a cross between group therapy and social-group work. Patients who have been treated either in groups or individually but are still not ready to participate in organized group life without close supervision and conform to routines and limitations of planned

group programs without a great deal of direction require a transitional period in social living. Transitional groups provide the experience needed by these children in the continuation of their process of adjustment to everyday social life. In these groups food, materials, and similar services are not supplied. There is a definite organization; the group meets in a regular settlement house or neighborhood center as a "club" and carries out planned activities. The children are encouraged to elect a president, secretary, treasurer, and other officials, and they collect dues and manage their affairs with the help of the leader. The leader is no longer passive or neutral but participates in the planning, exerts leadership influence, and helps the children to carry out their plans.

The difference between the ordinary club leader and the leader of a transitional group lies in the fact that the latter is aware of the children's problems and difficulties in adjustment to group situations. He helps them by making certain that the program is not too difficult for the group to carry out. He also encourages the group in its program activities, keeping in mind at all times the needs and difficulties of each member and giving individual assistance where necessary. Unlike the leader of an educational group, he does not treat the group as a mass but individualizes his work and prevents anxiety and failure in children who are still frightened or too aggressive to make their way into the group situation. The group as a whole and the children as individuals are slowly introduced into the activities of the center. This may involve the development of special interests in such fields as art, dramatics, athletics, shop work, or science; or the transitional group as a unit may participate in planned activities. The usual procedure is to suggest trips around the center, so that the members can see the activities at first hand and perhaps join in those in which they find an interest.

Transitional groups are sometimes referred to as "protected groups" and have been found to be quite valuable for children who still have reservations or are psychologically unready to participate fully in the activities of a mass program. Some of the members of these groups cannot adjust to larger and unprotected group activities

and relationships and have to be returned to the clinic for treatment.

Play-Group Therapy

We have found it necessary to introduce a play technique for groups of very young children of preschool age in order to meet their peculiar needs. This treatment is known as *play-group therapy*. In this technique the same principles and procedures employed in individual treatment are used, but with some modifications; the physical setting is similar to that of activity-group therapy. Groups of three or four children four to five years of age are provided with materials through which they can act out their fantasies, hostilities, and other problems that can be expressed and clarified through games, pretense play, and such simple activities as dabbling with water-color paints or clay and engaging in other occupations which they frequently evolve themselves.

The differences between these and activity therapy groups lie in several areas. The groups are smaller in number, and the room is considerably smaller. The materials provided are simpler and more suitable for fantasy play than serious or practical work. Toys, rather than tools and raw materials, are supplied. Another basic difference is that the things supplied include what we call *libido-evoking* or *libido-activating* materials. These are objects that evoke expression of oral, anal, urethral, sexual, and interpersonal confusions and preoccupations. With these materials children can act out their preferences, hostilities, destructiveness, and other drives toward members of the families and abreact to repressed or fear-evoking impulses and fantasies. The center of activity is a dollhouse with a number of rooms and appropriate furniture and a series of dolls representing a male, a female, children, and babies, as well as animal toys and masks that serve in acting out fantasies and fears.

As could be expected, the rooms that receive most attention in the doll house are the bathroom and the bedroom. The young patients use the furnishings supplied for them in a great variety of ways and in accordance with the attitudes and feelings of each child. Some

put the parent dolls in one bed and a child doll or children dolls in an adjoining room or in the same bed; others put the mother doll and the child dolls in one bed and the father doll in another room or leave out the father doll altogether. Another child may put the father doll under the bed or leave him out of doors. Similar attitudes are expressed toward siblings, which may be placed in various rooms and in different positions or may be thrown out of windows and "killed." The lavatory is an important focus of interest among young patients. Various dolls may be placed upon the toilet bowl, and so on.

The treatment accorded animals as representative of siblings or sources of parental affection is important, and the way in which the children employ the masks to represent themselves is equally significant. These various patterns of response are not only important as diagnostic evidence and as a means for better understanding of the child's problems but are also employed for direct interpretation. The child's activity is interpreted to him within his level of understanding. It is explained that hostilities and acting out stem from intrafamilial and interpersonal relations in the home. Even a young child can be led to recognize his own feelings and his wishes for a better life setting, friendlier people, and better treatment. He easily recognizes his fantasies and cravings for the elimination of persons who interfere with the gratification of infantile desires, these fantasies and cravings are brought out at an appropriate time and in a proper manner by a skillful and well-trained therapist.

Aggressions and friendships among children and their games and stories are also interpreted in terms of resolving conflicts, guilt, and anxieties. In this manner the child's tensions are reduced, his suspiciousness and hostility diminished. As a result he becomes a better adjusted individual; and when the mother is also treated, the total setting of the family is improved and harmonized. Thus, many problems that might eventually become constellated into full-fledged personality or neurotic disturbances are averted.

Activity-Interview Group Therapy

A somewhat similar technique, known as *activity-interview group therapy*, is employed with children of school age. The setting of these groups is the same as in activity group therapy, except that fewer provisions are made for constructional and creative activities with raw materials and tools. Here the children are kept rather more to a play and conversational level. A dollhouse and appropriate furnishings used in play-group psychotherapy are present, and simple materials that require no tools or special setting, such as clay and paints, are also provided. Interest is focused on conversations of the children and their interactions with one another. Dramatic plays, stories, and reports of experiences are of major interest. As in individual-play therapy, here also the children talk about their personal problems, preoccupations, fantasies, strivings, hopes, and desires. These are dislodged from repression and are permitted to be evaluated and understood through the awakening awareness and increased ego strengths.*

SOME PRECAUTIONARY CONSIDERATIONS

Certain risks are present in the free play of disturbed children in play-group and in activity-interview group psychotherapy. The tolerance of any given group (as, indeed, of any individual) to withstand or absorb hostility and aggression has a definite limit, and this point we refer to as the point of *tolerable hostility density*. When this limit is exceeded, tension and anxiety set in, which are expressed in hyperactivity, rowdiness, or wanton destructiveness. Unless restraints are applied by some outer agency, such as a parent, teacher, leader, or therapist, the group becomes severely disorganized and uncontrollable. This is true of all groups, whether children,

* For further and more detailed descriptions of the various types of group treatment evolved by the writer, see references (10) and (15) of the bibliography at the end of the chapter.

adolescents, or adults, and it is the primary reason why selection and grouping are so important. It has also been observed that different members of groups are affected differently by boisterous overt behavior or by repressed hostility. The endurance for these emotions varies in different individuals.

In the young child the superego is still unformed, and during the pre-Oedipal and latency stages the executive functions of the ego are less effectual than they are during later development. The young child, therefore, is still devoid of the controls that emanate from the repressions and inhibitions that are only partly evolved or not evolved at all. In view of these conditions, the function of the therapist (parent and teacher as well) in dealing with young children is in fundamental respects unlike his function in groups of older patients. With young children he needs to be more active and more fully in control of both group and individual activities.

In group play, patterns of behavior and problems emerge that are not present in the play of one child, since interstimulation and various types of interaction inevitably arise from the concurrent activity of several children. We refer to this mutual influence as the *catalytic effect*. The anxiety stimulated by the presence of others and the support that the members of the group give one another in their hostility toward the adult induce hyperactivity and destructiveness seldom encountered in the play of one child. Therefore, it is necessary that the therapist be more vigilant in detecting trends and possible developments in a group than in the treatment of one child and employing strategies and techniques to prevent disorganization, emotional tension, and excessive anxiety. Since the young child's unconscious is near the surface, it is not difficult to stimulate the flow of the unconscious in play activity which may have meaning to him in terms of his specific personality problem and needs or may even be detrimental to him at a given stage in treatment.

We have already shown that acting out has value only when it is related to the unconscious of the child and his emotional conflict (19). Diffuse hyperactivity that may express hostility toward the environment, including the therapist, is in itself not therapeutic. The

value of acting out lies in the relation that it has to the conflicts of the patient. Acting out of hostility by an older child, an adolescent, or an adult is likely to lead to conscious recognition of the true intent and significance of his actions, an awareness that is evident in various forms of guilt manifestations, such as confession, placation, submission, and restitution, all of which indicate the presence of superego formation. The superego, however, is still absent in the very young child. Acting out does not bring about insight into the meaning of behavior and therefore has little or no therapeutic value beyond release. Because of this absence of superego formation, low degree of guilt, weak ego structure, and basic narcissism, acting out alone does not meet the treatment conditions of group psychotherapy.

Acting out has to be limited, restrained, and directed in the analytic group treatment of young children (a different procedure from that employed in activity groups), but at the same time it is necessary that the therapist call attention to the latent meaning of behavior. This form of interpretation has several therapeutic values. First, positive transference is evoked, because the child feels he is understood by the therapist. Second, interpretation makes him aware of his real problems and the meaning of the hostile intent of his behavior. He becomes vaguely aware of the fact that his aggressive behavior in the group is only an expression of hostilities he feels toward other persons. Third, in a more neurotic child, interpretation serves to bring forward impulses, conflicts, and anxieties and makes the young patient aware of his real difficulties.

When using play therapy, whether in a group or individually, the therapist must be aware of the significance and meaning of play in its many facets. He must recognize that play to a child is what serious, productive work is to an older person, that through play the child carries out the tasks of his life, and that he uses play for many other ends as well. To review the many theories of play, such as experimentation with reality, expression of excess energy, recapitulation of the phylogenetic experience of the race, mastery, or as an effort to attenuate reality, would take us far afield.

To the therapist play has special meaning. He knows that through play the child expresses traumatic fixations, conflicts, and hostilities and that he employs play as a form of abreaction. The therapist knows, too, that the child also uses play as a means of disguising genuine conflicts and difficulties or of relaxing tension and anxiety. Of greatest importance, especially to the group therapist, is the fact that as the young patient discharges aggression and seeks to overcome traumatic anxieties through play, it acts as a regulative mechanism. The therapist also sees group play as a possible means for overcoming narcissistic and autistic fixations and for discharging libido centrifugally through relationships with others in the group. The child discovers the advantages of such relationships, and his ego-libido drives are redirected outwardly toward his playmates and the objects he uses in his play, which are usually cathexized.

The play therapist also is aware of the importance of play as a sublimation of primary instinctual drives, which in their primitive form are socially not acceptable. The service of play in finding permissible and acceptable outlets for primary impulses is of considerable value in therapy. Play is greatly facilitated by the catalytic effect of the others in a group, which makes it easier for the individual to act out and to bring forth in behavior and conversation fantasies and ideas that are threatening to him.

Another valuable contribution of the group is that it reduces the tendency to repetition. The young child, particularly, tends to repeat the same activity, a propensity due largely to the limited scope of his capacities and experiences and the security that a known situation gives him. He is either afraid or unable to evolve variety in the use of play materials. However, when several children play together, their interaction and mutual support help the individual child to employ the materials progressively rather than to become fixed at one level of self-expression. This has been observed in educational and therapy groups and constitutes what is often referred to as a *growth-producing environment*.

In play groups—and this is to a great extent also true of other groups—children assign to themselves roles that are an expression or

an extension of their basic problems. In such roles one plays out either the awareness of what he is or a hopeful fantasy of what he would like to be. Thus, a child playing the role of a dog may feel himself being treated with the same indifference and as impersonally as is the dog; or he may seek to get the loving acceptance and protection that a pet receives in the home; or he may attribute to himself the oral strength that is usually associated with dogs. In a group such fantasies are reinforced and find easy and natural means of coming through in a variety of play forms and activity channels.

ILLUSTRATIVE CASES

To illustrate some of the general principles of play groups, the following abstract of a record is included with brief comments on some of the major dynamics of the events that took place in the group, which consisted of three boys, five to six years old (19).

. . . (John is the first to arrive and seems a little more friendly than during the past few weeks.)

JOHN: Where's everybody?

THER.: They'll be along soon.

(John seems to have considerable hesitation in coming to the playroom where the group meets, but he finally does so when the therapist says that the others are coming soon.)

JOHN *(immediately going over to get paper)*: I want a lot of colored paper. Who was here last week?

THER.: Judah and Mike.

JOHN *(angrily)*: My mother said nobody was here last week. Where is Mike?

THER.: Mike will be coming.

JOHN *(he seems very restless)*: I am going to my mother. Mike isn't here.

THER.: Why are you going to your mother, John?

JOHN: I am going to get a nickel. My mother said nobody was here last week, and now she has to give me a nickel.

Ther.: John, you can go to your mother after our meeting, but I think you should stay here now.

(John seems to hesitate and wanders around the room. He looks at the paper. He comes over to the therapist and puts his paper down.)

John: I'm not going to stay, because Mike isn't here.

Ther.: John, are you afraid to be here in the meeting room alone with me?

(John does not answer but seems to get relief from the therapist's saying this. He relaxes immediately.)

John: I am going to work on my plane.

(He begins to saw, which he does very well.)

John *(speaking proudly and boastfully)*: Look at the thirty cents that I got from my grandfather. My girl friend Janet also gives me money.

(He shows the therapist the thirty cents.)

John feels uncomfortable alone with the therapist. This discomfort is due partly to his hostility displaced from his mother onto the therapist and partly to his sexual preoccupations in regard to the former. He substitutes the therapist for his mother, and the same anxieties that are associated with her come to the surface now.

John is disappointed that the therapist, like his own mother, has not given him siblings (playmates). She (the therapist) disappoints him, and he is angry with her; he wants to punish her by leaving her and going to his mother, whom he plans to exploit for lying to him, which is probably his fantasy.

When the therapist interprets to John his feelings toward her, he at once relaxes and settles down to work. Because the therapist understood him, she is less threatening. To be understood also means to be accepted, and his negative transference is at once changed into positive feelings. As a result of this rapport, John feels secure and boasts that he is liked by others as well. Even his girl friend gives him money. In this is implied a defense against his sexual impulses, as well as hostile feelings toward the therapist. She is not the only one in his affections, there are others; that is, the basic transference is a negative one.

. . . (Mike arrives and appears to be angry. He is the strongest member of the group, the one on whom John relies and whom he fears.)

MIKE (to the therapist): I was waiting for you downstairs.

(Judah arrives wearing a mask.)

JUDAH: We put paint all around your office because you weren't there.

THER.: I waited until our time to go upstairs. If you were angry, you boys could have told me rather than painted my office.

JUDAH (enthusiastically): My uncle gave me this mask. He just got back from overseas and, boy, you should see the souvenirs he brought for me.

(Mike finds some candy that was left from the last meeting and grabs it.)

JOHN (trying to grab the candy from Mike): That candy belongs to me. Give it to me.

(Mike and John start running around the room, while John keeps trying to get the candy from Mike.)

MIKE: It does not belong to you and you can't have any candy.

JOHN: The candy is so mine.

MIKE (throwing a piece of candy across the room): There you are. Run and get it.

JOHN (picking up the candy): Come on, give me some more. The rest is really mine.

MIKE (throwing another piece which John runs after): And you're not getting any more.

JOHN: I'm going to run out and tell my mother.

THER.: Why are you going to tell your mother?

JOHN: I'll tell Mike's mother.

THER.: Why don't you tell Mike?

(John ignores the suggestion of the therapist. Mike stops fighting him.)

MIKE (to Judah): Why don't we go out and get water for the painting?

(Mike and Judah go out to get water for the finger painting. John begins to work with the paper, cutting out a design on orange paper which he had crayoned black. Judah and Mike come running back into the room.)

JUDAH: I am going to make a witch picture.

MIKE: I am making a Hallowe'en picture, too.

(The boys work for a while. Then Mike tries to put paint from his hand on John. Judah follows and tries to do this also.)

THER. (to Judah and Mike): Why are you boys angry at John?

MIKE: Because John got here early.

THER.: But John got here at the time he was brought. Mike, maybe you just don't like the idea that someone else is here alone with me.

MIKE: You're right.

(Mike then pretends to dab paint in John's direction without really doing so.)

THER.: Mike, you just feel like acting silly now.

MIKE: Gee, you're right again. You're becoming a mind reader!

Both Mike and Judah are angry. It is easy to guess the cause of their anger. They act out their anger against the therapist by messing up her office, which is in another part of the building, and by depriving John of candy. Later, Mike, the most disturbed of the three boys, reveals the reason for his hostility toward John. He acts out his sibling rivalry, and as the therapist helps him to understand that he is jealous of John for being alone with her, his anger abates. He pretends to throw paint at John but does not actually do it. The therapist is somewhat defensive about John; she seems to justify, or at least explain, his being alone with her. This can be interpreted as meaning that she prefers John, which is both bad and untrue. The interpretation of Mike's feelings alone would have been sufficient. When the therapist says that Mike is just being silly, she expresses her disapproval and exercises control over him, which is necessary with very young children.

. . . *(All three boys go on working; Judah finishes his painting.)*

JUDAH: Well, that's done. I guess I'll work on an airplane now. *(To the therapist):* Would you help me?

(Mike has started several "war paintings" all at the same time. He finishes them all at the same time after working diligently. The therapist sees no design in them, although she believes that Mike is using his hands more freely and is actually finger painting rather than working the way he

did last week, which was just piling paint. Judah draws an airplane on wood and comes over to the therapist.)

JUDAH: Will you saw this for me? Gee, I'm glad you got the saw you promised me.

JOHN (*moving closer to the therapist*): Would you make me something, too?

THER.: Of course I would.

(John seems very pleased at this.)

JUDAH: Gee, I have an idea. Let's all make pumpkins out of wood. This is how we could do it. All we have to do is to nail pieces of wood together into a square.

JOHN (*to the therapist*): Could you help me saw this piece of heavy wood?

(Judah then starts to nail the two pieces together but has to hunt for the nails. John goes over to him and hands him a nail that he has found.)

JUDAH: Thanks a lot. *(John seems pleased by this.)* John, come on and help me with this work. You could even start one for yourself.

The hostility felt by Mike and Judah is now sublimated in activity: airplanes and war paintings. The therapist, however, notes that Mike is much freer in his work, which is very important for this boy. Judah is pleased that the therapist got the saw he wanted and, because of this warm feeling toward her, wants her help—an expression of sibling rivalry. When John gives Judah the nail and Judah in turn invites him to work with him, there are personality growth beyond narcissistic preoccupations and an expanded capacity for object relationships. John's act can be seen, however, as a placation because of his own fear of the hostile feelings he harbors toward Judah, but as Judah accepts him (that is, forgives him), he feels relieved.

. . . MIKE: Let's all go now.

JUDAH: I want to finish.

(Judah leaves his wood and takes some of the paint, with which he starts to paint a picture on the wall.)

THER. (*to Judah*): You know we are not allowed to paint on the walls of the room.

JUDAH: Oh, don't worry. It will be okay because no one will know that I did it.

THER.: That doesn't matter. We are still not permitted to paint the walls.

JUDAH (*continuing to paint*): I won't be found out. (*Painting a picture of a house and one of an owl.*) I think it will be all right. Look at the paint that other people put on the wall.

THER.: Maybe you are angry because other people use this room.

JUDAH: That's right.

MIKE (*chiming in*): You're right.

THER.: You see the toy cars are ours and so is the bulletin board If you want to leave, I think we should go now.

(*They all want to go.*)

I think you should all go outside and wash.

(*They follow the suggestion. This is the first time that any of them has gone to wash his hands before going to eat. Because someone is in the washroom there is some delay, and Mike starts banging on the door. Judah runs for a hammer and starts banging. John also participates, kicking the door and banging on it. They are finally able to get inside.*)

JUDAH (*to the therapist*): Would you get paper for me? I want you to lift me up so that I can get the paper for myself.

MIKE: I want paper, too.

JOHN: Me, too.

Judah and John are with the therapist. This disturbs Mike, and he suggests terminating the session. Judah does not want to go, and because the therapist does not counter Mike's suggestion, he attacks her by painting the wall. When she remonstrates with him, he finds every plausible means for justifying his act, and, finally, he and Mike admit that they are angry because others, as well as they, use the room; that is, the therapist loves other children as well as them. Judah's choice to paint a house and an owl is in itself significant.

The fact that John, a frightened and withdrawn boy, can participate in an act of such direct aggression as banging and kicking the door is very valuable to him. He could not possibly have done it when alone. The example (catalysis) of the others gave him the courage to do it.

. . . JUDAH: Let's go down through the back stairway.

(The group follows Judah's suggestion. There is no running ahead, all three walking alongside the therapist. Judah and Mike take her hand and John takes Judah's hand.)

JUDAH: Let's stop at the stationery store.

MIKE: Yes. I see something I want.

JOHN: That's a good idea. I see something, too.

JUDAH: I want a collection of books, but all the things cost too much.

I only have a dime.

(Judah gives up the idea with some difficulty.)

MIKE: Let's go now. I think we should stop and eat first, though.

(Judah and John agree, and they all choose vanilla ice-cream sodas and eat without playing with the ice-cream as they formerly did.)

THER. *(while the boys are eating)*: What would you like to eat next week?

JUDAH: Frankfurters.

MIKE: Yes, frankfurters.

JOHN: That's right, frankfurters.

JUDAH: And please have plates and forks and knives and mustard and flowers—daffodils—and then we'll all sing: "Here comes the bride."

THER.: Who is going to be the bride?

(Judah does not answer.)

The back stairway is dark and has special significance for these boys, as it also has for the children in other groups. They are afraid and keep together and cling to the therapist. Note that John, because of his timidity and fear of contact with the therapist, holds another boy's hand both on this occasion and on a later one. In the discussion of refreshments, Judah brings forth the idea of a bride. Did he see himself marrying the therapist (his mother)? One can only speculate on this. When asked by the therapist who the bride would be, he does not answer but represses whatever fantasy is behind the statement.

. . . *(On the way to the five-and-ten-cent store, John tries to put chalk on the therapist, and Mike hits her with a gun, which really takes the form of pushing the therapist from the back. Mike and Judah then take*

the therapist's hand, and John takes Judah's hand again. John keeps taking out his thirty cents to show how much money he has. In the store they hesitate a great deal about choosing what to buy, looking at all the various objects before Mike finally decides.

MIKE: I'm going to buy stickers and tags for Christmas packages.

JUDAH: I want tags and stickers, too. *(He decides this although he had been handling something else.)*

JOHN: I'm getting them, too.

(John also buys crayons that Judah had picked up but didn't have the money to pay for. The group walks back to the office.)

JUDAH: I would like to have a hundred thousand dollars and buy a big store.

MIKE: I would, too.

JOHN: So would I.

The following record of an activity therapy group session of boys nine to ten years of age demonstrates the permissive environment, the neutral role of the therapist, the free accessibility of the total setting, group mobility, spontaneity, interpersonal reactions, and numerous other dynamics inherent in this situation.

The therapist arrived at the meeting room before anyone was there. About ten minutes later August walked in, entering quietly as he usually does. He did not greet the therapist but did watch in interested fashion as the latter began to remove the new tools he had brought to the meeting room. Once in a while August picked one up and held it tentatively, still without comment. (His expression rarely, if ever, becomes animated. More often there is an unfathomable, open-eyed staring. His lips are constantly moist, and occasionally an accumulation of moisture drips down the corner of his mouth.)

About five minutes later, Frank came into the room with an expression of alertness, as if he anticipated this meeting. This was the second meeting he had attended, and he obviously came alone, since the therapist saw no one with him, and there was no one on the landing. Frank exhibited some interest in the new tools spread out on the table with the other supplies and then began to handle them, commenting to the therapist that they were "swell."

Jerry then entered the room. He, too, came in quickly, as if trying to

determine whether he had missed anything. He made no comment about anything that had happened in the previous meeting, during which the therapist had been forced to remove him from the meeting room, and at no time during the present meeting did he say anything to recall the incident of the previous week. Jerry examined the new materials with avidity. He said to the therapist, "Did the darts come?" The therapist replied in the negative. (Jerry had earlier requested a dart game. The therapist intends to bring a game of darts to the following meeting, but of the magnetic variety, without headpoints.)

Donald then entered the room, accompanied by his mother. Once more she stood in the room near the doorway, as she usually does, and engaged in conversation with Donald, who acted as though he would have liked to ignore her. She spoke in a loud voice and again dwelt on the project that she wanted him to work on. Since the therapist ignored her, she took a chair and went downstairs.

Frank took from the storage cabinet the wooden machine gun which he had nearly finished the previous week. He brought it to the therapist to show his progress and indicated what he was going to do. The therapist told him it was good. Jerry was still examining new tools and seemed to the therapist to be taking an almost proprietary interest in them. Of most significance, in view of his difficulty with the therapist during the previous meeting, is the fact that a few minutes later he gave the therapist a razor blade and said, "This we can use in that holder." The therapist placed the blade in the holder and put it on the table. Donald, meanwhile, obtained some lumber and began to saw at the woodworking machine near the Ping-pong table. (Donald invariably withdraws to an isolated position. Occasionally there is someone working near by, but he is generally alone.)

August wandered around the room ghostlike, without saying anything to the other boys. His wide, staring eyes took in everything that was going on. At one point he came and asked the therapist to help him make a small change purse. However, he withdrew after making his request, and the therapist continued the project for him. As it was nearly finished, August came up to the therapist to see how things were going. The latter gave him the cord and showed him how to lace the purse. When he found that August was either reluctant or unskilled, he finished it after the boy handed the purse to him. (The therapist has made several things for August during the last two sessions.)

The therapist observed August climbing up on the storage cabinet to sit on top. (He has done this before and seems to enjoy it. When on top, he remains for about five or ten minutes, gazing about the room; the others generally ignore him.) Later, Donald, too, tried to climb up to join him but found it too difficult. (Donald is rather heavy and is not as agile as some of the other boys.)

Frank came to the therapist with a rather wry expression on his face and showed him how the handle had broken off the machine gun he was making. The therapist explained how he could put on a new one and helped him get started. Much later the therapist observed that Frank had laid this aside and was making a stool.

Jerry had been trying several of the tools experimentally. He took a set of drill points apart and brought them to the therapist to show that there were five. When he asked where they fitted, the therapist gave him the small fiddler drills. He tried drilling into small pieces of wood with the small drills and then asked whether he could have one of the cheese boxes that the therapist had brought. The therapist answered in the affirmative, and Jerry proceeded to cut small openings in the side of the box. He came to the therapist periodically to show his progress, and the therapist praised him. Jerry explained that it was a marble game where boys could shoot marbles into the hole. (Jerry did not take the box home with him, so the therapist stored it after the meeting.) Later in the session, Jerry volunteered to help the therapist, who was making a toolbox. He was obviously making an effort to reinstate himself with the therapist as a result of the previous week's episode. The therapist met all his requests without comment, and Jerry became more secure as the session progressed.

Donald came several times for help. Although he gives the impression of being unskilled with tools and infantile in manner, the therapist has observed that his projects are imaginative and his skill satisfactory. On occasion he does attempt projects that are a little too difficult, and the results are not too good, but the therapist makes no comment. For instance, in making a bench he used one whole plank of wood for the top. Up to this point the therapist has felt it unwise to volunteer his help, since Donald has displayed no frustration or anxiety in his work. When he requests help, the therapist freely gives it to him.

About an hour later, Jerry came to the therapist and asked, "Mister,

can I have a light?" The therapist searched his pockets and found that he did not have his cigarette lighter with him. (This was prearranged.) Jerry then asked for a match. While this was going on, Donald walked over and said gaily, "Let's build another big fire." The therapist made a display of searching all his pockets and showed the boys that he obviously had no matches either. (This, too, was planned in advance.) Of the two boys, Donald seemed disappointed; Jerry went on to other things.

The therapist was engaged in finishing the little purse for August and was seated at the end of the long table near the Ping-pong table when Jerry put out half the room lights at the switch near the entrance door. This intrigued Donald, who left his work and proceeded to put out the remaining lights at the switch near the Ping-pong table. The room was dark, particularly near where Frank was standing. Frank yelled, "Put on the lights." The therapist continued to work in the darkness without comment. Frank then called out to him, "He doesn't put on the lights." The therapist neither looked up nor made any comment.

Jerry began to blow a whistle which was suspended from his neck on a string. The din was piercing. He walked around the room, blowing the whistle vigorously and laughing. Frank ran up to the switch near the door and put the lights on. When he returned to the table, Jerry again put the lights out. Donald was standing with his hand on the switch on the other side, laughing aloud, and seemed to be having a wonderful time.

At this point August, who had spoken practically nothing during the entire session, walked over to the switch that Donald was holding and put on the light. Donald again turned them off, and August initiated a wrestling match. The boys were struggling for the switch, and the lights were going on and off. Donald called to Jerry, "Hey, Jerry, help me." Jerry, however, did not relinquish his position at the other switch. August was successful in having the lights put on at his end of the room, but when he left the switch, Donald ran back and put out the lights. Now Frank began to object again, because he obviously could not work on his lumber with the lights out. He went over to Jerry, who was still standing at the switch, and said more threateningly, "You put those lights on!" Jerry said, "You got enough light to work." Donald said to the therapist, "Can't we keep the lights out?" The therapist did not comment, and Donald, taking this as an affirmative answer, called out victoriously, "You see, he doesn't mind." As Frank was tussling with Jerry at the switch (but

not too vigorously), he successfully got Jerry away from the switch and put the lights on. Jerry then turned them off once more, and Frank, obviously angered, decided to work in the dark.

Jerry continued to blow his whistle, and he and Donald stood at the respective light switches. Once more Frank went to the switch and again wrestled with Jerry. Although he is more than a full head taller than Jerry and much heavier, Frank seemed fearful of provoking an actual fight. Jerry, on the other hand, seemed unafraid of the taller boy. After about fifteen minutes of this, the boys decided to leave the lights on.

After a while Jerry asked the therapist, "Where's the key? No bags?" The therapist replied that they would eat out. This seemed to please him, and Frank, who was standing near by, said, "Can we have frankfurters?" Before the therapist could reply, he said, "I asked my worker [caseworker] if we had frankfurters in the club and he said that we would." The therapist replied that they could have frankfurters. The therapist was now clearing away, and another boy helped. When all the supplies had been put away and the table tops cleared, the therapist locked the large cabinet and went for his coat. When the boys saw this, they ran for their jackets and joined him near the door. The therapist put out the lights, and the boys accompanied him downstairs, Jerry continuing to blow his whistle strenuously. Donald's mother was still seated on the sidewalk in front of the building, and her son called out to her, "Ma, we are going to eat outside." She asked him, "Are you coming back?" The boy did not answer, but the therapist told her that they all would return shortly.

The therapist and the boys went across the street to the delicatessen store and noisily sat down at a table, where the therapist ordered frankfurters for all and the boys announced their selection of sodas. They seemed to enjoy themselves, and although Jerry was somewhat noisy and another boy laughed loudly, they behaved in acceptable fashion. When they had finished the refreshments and were preparing to leave, Jerry began blowing his police whistle again very loudly. The owner of the store, with irritation, ordered him to stop, and Jerry did so. As the therapist left the store with the boys, a horse and wagon were going by. Jerry quickly called to August, "Let's grab it and ride." Both boys ran for the tail of the wagon and attempted to get up on it. For about half a block, they were up and down and finally left the wagon and continued walking.

Frank went in the other direction to get his bus, first saying goodbye to the therapist. Donald, still licking his fingers in reminiscence of the

frankfurter and soda he had had, accompanied the therapist across the street to the meeting room to meet his mother. The therapist told Donald's mother that he would take the chair upstairs, for which she thanked him. He went upstairs and opened the door. When he entered the room he heard footsteps behind him, and Frank came into the room. Frank said, "I've got to go to the toilet," and added that the bus wasn't there yet. He went into the toilet, came out, and left once more.

DIRECTIVE METHODS

Other types of group psychotherapy can be classified under the general title of *directed group psychotherapies*. The reason for adopting this term is that the discussions in these groups are predominantly planned or directed by the therapist. In some of these groups specific material is presented to the patients, such as a case history illustrating specific psychological concepts and principles. In others, lectures are given to large groups of patients on mental health, general psychology, psychopathology, and allied subjects. Some psychiatrists use textbooks on psychological topics, which the patients read and discuss under direction, in much the same way as in adult education classes. Patients may ask questions which are answered either by fellow patients or by the therapist. The content of such "class" discussions is also drawn from general science, literature, sociology, newspapers, and current events which may or may not be related to the patients' problems and preoccupations.

In some instances, attempts are made to create a favorable group morale and an optimistic outlook on the part of patients and to inspire in them wholesome attitudes and understanding of psychological processes involved in their difficulties. For this purpose slides and films are used to illustrate psychodynamics and body changes in such states as anger, fear, depression, projection, sublimation, and so on. These and related techniques are sometimes referred to as the *class method* of psychotherapy and can be inspirational, repressive, educational, or didactic.

Some psychotherapists use the guidance approach and advice giving; others impose rather strict rules for behavior on the job and in social activities that help maintain in patients a balance between the intrapsychic forces and external pressures. This latter method can be designated as the *inspirational-authoritarian method*. The group motivates the patient's self-control, activates self-awareness in dealing with external reality, and helps him understand his attitudes and reactions. The authoritarian element emanates from the therapist's exertion of direct authority. In some instances, this authority is delegated to other, older patients who direct the more recent members of the group.

In the category of directed group psychotherapy are also included the less formalized and less didactic and authoritarian methods in which the psychotherapist conducts the group interviews in accordance with a specific plan of his own. Some therapists employ the *rotation method*. In this technique, individual patients are called upon to state their problems and give their reactions in a given order so that only one patient is treated at a time while the other patients are placed in the role of spectators.

In another of the directed group therapies, the psychotherapist directs the patients to bring in specific material about themselves and their backgrounds or instructs them to memorize and relate dreams. These are used as the starting point for further discussion. In some instances, free association can be used by patients after the initial statement is made on the basis of the directed material. Other psychotherapists limit the scope of the patients' discussions. They narrow the field of free association and canalize it toward areas in which the therapist wishes the group to move.

Still another type is the *group counseling and guidance method*. In this method all psychological discussions are avoided. The content of the interviews is confined to immediate and practical situations for the purpose of eliciting better understanding and self-reliance. Like other techniques of this order, it employs intellectual understanding and ego support and by and large deals with current matters, conflicts, and difficulties. The exchange of opinion among

the participants results in better clarity, a degree of reconceptualization, universalization, and objectification that are helpful to persons in distress.

Most of these techniques rely on exploration by questioning patients in order to uncover information that patients may not give freely, and all of them have the effect of limiting or circumscribing free association, free catharsis, and psychological regression toward traumata. For this reason the directed therapies do not reach deeper layers of the psychic organization of the patient's personality, nor do they help work through basic problems, even though they alleviate immediate pressures and help in the management of everyday affairs.

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Psychotherapy Based on Psychoanalytic Principles

Norman Reider

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Since the time of Aristotle and Plato, many scientists and philosophers have been aware of the impact of unconscious factors and the importance of understanding mental processes. It remained for Sigmund Freud, however, as a more or less direct result of his work with Charcot, Bernheim, Janet, and Breuer, to establish the unconscious as a sphere for scientific study and investigation. The groundwork for psychoanalysis was laid by Freud and Josef Breuer in their work with hysterical symptoms during 1887 to 1895, which led to the publication of *Studies in Hysteria* (1893). Since that time the development of psychoanalysis has been incorporated into many theories of personality, and few psychotherapeutic approaches have failed to utilize psychoanalytic principles in terms of either theory or technique. The influence of psychoanalysis is apparent in the number of scientific papers on the subject that appear each year and in this book in the frequency of references to it and the general importance attributed to it by each author.

Claiming little originality for his therapeutic approach, Dr. Reider has, nevertheless, incorporated psychoanalytic principles in the presentation of the material in a highly individual manner, which reveals his interesting psychotherapeutic approach.

Psychotherapy Based on Psychoanalytic Principles

THIS CHAPTER will be concerned with derivatives of psychoanalytic principles that lead to a type of psychotherapy which is, in my opinion, still too complex to be systematized thoroughly as a technique capable of standing the test of rigid methodological scrutiny. It is possible that many personal elements concerned with intuitive factors, with identification with previous teachers, and with one's mood in response to a given patient or a given clinical situation color the clinical experience to such an extent that a thorough description might become a literary production rather than a scientific report.

Only a very small amount of the following material is original, for I am dependent upon many authors, teachers, and colleagues for various formulations. Few references are given, since there are already extensive lists of these in the literature. While acknowledging these sources, I shall nevertheless present the material in my own way and shall be responsible for defects in the mode or in the substance of the data.

THEORETICAL CONSIDERATIONS

Theories of personality may be cosmic in proportion and content. A theory that holds that man has a special role and function in the nature of the universe, that he draws his energies from cosmic or supernatural forces, must of necessity lead to hypotheses that can never be tested scientifically and are, in the main, dependent

for practice on primitive thinking and authoritarian attitudes. Such theories, essentially idealistic or religious in nature, would have to be rejected as unsuitable in the long run, since they would eventually run into methodological contradictions that are inherently insoluble. On the other hand, a theory of personality may be too limited. For example, a theory that depends solely upon the functioning of the central nervous system or the endocrines, or a combination of both, has within it no possible means for explaining the nuances of human difficulties or the nature of conflicts and, at least at present, seems to hold no theoretical constructs that will lead to a technique of therapy.

This is neither the time nor the place for a discussion of the way in which psychoanalytic theory avoids these methodological pitfalls. Some general acquaintance with Freudian theory will be assumed. Briefly, it can be stated that psychoanalysis is a genetic psychology, biologically oriented, with dynamic, economic, and structural systems. On the basis of its theoretical structure it is also a therapy whose main purpose is the undoing of pathogenic defenses. In spite of its incompleteness, great gaps in knowledge, untested hypotheses, and multiple emphases, psychoanalysis remains the only psychological system in which there is a high degree of correspondence between theory and technique. It also forms a basis for the understanding of clinical syndromes and of sociological and anthropological data. Interesting though excursions into these fields may be, they are not the province of our discussion.

With a few psychoanalytic concepts as points of departure, a discussion of some underlying premises of certain types of psychotherapy will be presented here. The primary purpose of this is to obtain bases of contrast and to illustrate frames of reference for therapeutic efforts in psychiatry.

Take as a model of many methods of treatment a traditional empirical attitude in medicine. It is time-tested, and its value as a reflection of our understanding of the nature of a disease has been proved. The method consists of studies in the direction of making a diagnosis and applying what is known against the disease proc-

esses, the various elements of which are condensed into that diagnosis. A residuum of this attitude is the hope that against a disease entity a therapeutic regime or, better yet, a single agent will be efficacious. This may be correct and may work well for the cure of infections or the removal of tumors. But the same attitude applied for psychiatric illnesses highly resists one's therapeutic armamentarium. For instance, if the aim of diagnostic studies is to determine only whether the condition is schizophrenic, in which case the treatment is to be insulin shock, or a depression, in which case electroshock is to be used, then a narrow, outmoded, primitive concept of disease is being followed. The same concept applies to directing efforts against any mental symptom. Actually, matters related to human difficulties are much more complex, even the relatively simple matter of diagnosis.

Such therapeutic efforts can best be understood if viewed as a kind of demonology. In the instances cited, the devil happens to be the diagnosis. The demonology of today seems only slightly more sophisticated as a bit of behavior or a clinical syndrome is called abnormal or immature, infantile, neurotic, dependent, aggressive, or hostile. These are the new sins, the new devils that have to be exorcised.

Various types of modern psychotherapeutic systems partake of this demonology and make of treatment practices a new sort of psychoanalytic morality. Frames of reference are frequently mixed so that it is difficult to know with what specific part of the theoretical structure one is dealing. Judgments of defects and evaluations of a quantitative and qualitative nature still color formulations about dynamics and lead to the erection of therapeutic aims. This incompleteness, partiality, and fragmentation are very characteristic of all types of psychotherapies that are not truly psychoanalytic. For instance, in discussions stemming out of the genetic frame of reference, one not infrequently hears the "oral personality" described as very dependent and "orality" as the noxious pathogenic agent that somehow has to be got rid of. At other times structural emphases are made, as when one speaks of a "weak ego" or a "too severe

superego." Now, these formulations may in themselves be correct, and good results may very well be obtained when it is demonstrated to the patient that he has too severe a superego or, in broader terms (usually more acceptable to the patient, since easier for him to comprehend), that his conscience is too strict. It is doubtful, however, whether such isolated frontal attacks, if they yield results, do so on any other basis than that of the patient complying with an authority in hopes of receiving something from him.

These examples can be extended through other psychoanalytic concepts. At times, formulations of cases are made as though the goal were to make conscious that which is unconscious. Sometimes the frame of reference is an economic one, and there are references to "too much libido invested" in this direction or that, or "too much energy bound up" in this defense or in this or that countertransference. Again these formulations may be correct, but since they are so frequently used operationally in therapy, the conclusion seems inescapable that they are value judgments, essentially moral in nature, attacked critically, with the expectation that if the bad defect is pointed out, the patient will learn and will sin no more—and so it sometimes happens.

Probably the dynamic aspect is used and misused in this way more frequently than any other in these types of psychotherapy. Examples are numerous. Projection, identification, overidentification, dependency, retaliatory provocative hostility, and aggression are pointed out as though the specific mechanism is a defect. These need by no means be semantic indulgences; again, they may actually be correct formulations but used in the service of the newer demonology. Still another concept rather often used now operationally and frequently out of correct context involves transference. Here, again, many present-day systems involve the manipulation of transference with implications and inferences that the transference is good or bad, a hostile one or a resistant one, about which something has to be done.

Further, within the past few years attention to the phenomenon of countertransference has increased; again, many authors empha-

size, or at any rate imply, that it is an abnormal condition about which something has to be corrected. These attitudes may be absolutely valid in their proper context. It is both difficult and untimely to demonstrate how many of these concepts are discussed and treated in a really anti-psychoanalytic manner under the guise of being psychoanalytic. Moreover, it may be correct in partial treatment to use these concepts in helping people get over their difficulties, but it should be recognized that the use of these devices in isolated brief therapies does not constitute psychoanalytic therapy or even "brief psychoanalytic therapy."

PRACTICAL CONSIDERATIONS

Some of the elements involved in the use of psychoanalytic insights without the use of the classic psychoanalytic method of therapy should be examined. Surely one great advance in the application of analytic principles has been in the hospital management of patients. It is true that knowledge of what goes on in the recovery of patients in an intelligent and understanding environment without any special psychotherapy is still incomplete; yet some dynamic and structural factors can be recognized. Here is a case example.

A fifty-two-year-old successful businessman in the course of a routine medical examination had, for the first time in his life, a blood Wassermann which was found to be positive. He reacted to this discovery with a profound depression, feelings of self-accusation, sinfulness, unworthiness, and the desire to die. He also manifested a strong need for punishment for his indulgence in the premarital sexual affair in which he must have contracted syphilis many years before.

Detailed study of his case revealed that he had always had a very severe superego which he appeased constantly by a strong drive toward success and that success in turn appeased his conscience by demonstrating to himself his own value and rectitude, thus maintaining his self-esteem. Being successful, according to the pattern under which he had grown up

in a small Middle Western farming town, consisted of being industrious, being able to show the fruits of one's labor by accumulation of simple goods, being respected by neighbors, and obtaining simple pleasures only after one had earned them by hard work. Not only did the entire community in which he was reared set this standard, but an additional event in the history of his family had given specific personal significance to this pattern for him. His father had also been hard working and industrious, but an accident and a long convalescence put him into debt which took many years to pay off. A general atmosphere that some unpredictable event might destroy all that one had labored for pervaded the home and created a feeling of apprehension and of being on guard. After helping his father pay off the debt, he struck out on his own at age twenty and established himself in a small business which prospered. He married, had children, had a relatively happy home life, and prided himself on his ability to send his children to college without their having to work their way through school. He prided himself also on his excellent health and had no knowledge that he had contracted syphilis, which, incidentally, was latent and had produced no evidence of body damage. The accidental discovery of positive serology precipitated his depression.

The knowledge about his illness and personality structure and the evidence of his need for punishment to appease his conscience were used to institute a regime gratifying this need. At the sanitarium he was treated without any special considerations and given a routine of daily endeavors including, at first, many menial tasks for which, when they were done, he received no especial praise. After about four months of being treated as a sort of hired hand who received only room and board for doing his chores, he felt a little better. Then, despite his protestations of inadequacy, it was insisted that he assume some responsibilities in the organization of several newly begun occupational-therapy projects that involved manual skill and hard work. Gradually he took over. He was commended for his endeavors rather grudgingly. Little by little his self-accusations stopped, and he began to be critical of the management of the sanitarium, made gestures of knowing how to do some things better, and finally demonstrated his independence by renewing his interest in his business activities and showing that he was ready to go home.

Consider some of the dynamic factors involved. This man's depression might very well have been set off not by discovery of

syphilis but by a loss in business or by death in the family. What is important is to recognize that his sense of integrity was dependent upon continued success and meeting his ego ideal. Interwoven into this whole personal system was the value of hard work, of punishment for misdeeds, and of keeping on the straight and narrow path.

When this system of maintaining his integrity failed, his integrity was reinstituted by the sanitarium regime that made him pay for his sins and reintroduced an old pattern supportive in the past, namely, that of industry, which yielded only long-time—not immediate—rewards, thus enabling him to pay off his debt and see himself free and independent once more. Important was the attitude maintained toward him of matter-of-fact, nonyielding firmness, an attitude which also tacitly implied that if he would do what was required of him he would recover. This was also a repetition of the sustaining pattern which conveyed the atmosphere of inexorability of certain ways of life that had surrounded him in his childhood and adolescence. It is noteworthy that throughout the patient's hospitalization no attempt was made to give him insight into the nature of his difficulties; he returned home and got along well without even the intellectual understanding of what had happened to him.

Examples could be multiplied to illustrate the use of the knowledge of psychoanalytic principle as pertaining to basic human needs and their derivatives and the arrangement of therapies based upon intelligent understanding of those needs. What is known in these fields is not entirely new. These points have been known intuitively from the time of the earliest man, but their complexity and the full recognition of the dynamics involved are of relatively recent development and study. The recognition of the basic needs for love and aggressive outlet forms the basis of all systematizations of the practical mental hygiene movements, whether in the upbringing of children, the development of educational systems, or the application of group relationships.

SPONTANEOUS CURES

With an organic disease as a model, the tendency has been in psychiatry to look upon some psychiatric entities as self-limiting (and upon some as hopeless). Beyond doubt, individuals have recovered from anxiety attacks, depressions, phobias, schizophrenic episodes, without any particular help from hospitalization or psychotherapy from psychiatrists, counsellors, or ministers. Again, the self-reparative physiological processes always operative in the body have long been known and classed under defense mechanisms as responsible for those cures that take place spontaneously when specific treatment against disease is not available.

In my early days in psychiatry, about fifteen years ago, I became attracted to the possibility of uncovering what might operate in the so-called spontaneous cures of psychiatric conditions with the hope that such data might yield information helpful in treatment. For instance, in the course of obtaining histories from patients who have had psychiatric difficulties prior to the one for which they came to be treated, it is useful at times to go into explicit details of a previous recovery in order to discover what resources within the patient may be utilized again for the present illness.

In so far as my personal experiences are concerned, the historical details turned out to be disappointingly less helpful in the patient's present illness than had been hoped for.

Several reasons were involved. Very frequently, even in instances of analytic treatment, the data uncovered did not yield clear and definite enough indications, beyond some multiple possibilities or speculations as to the improvement. Another factor often discovered was a change of symptom. Replacing the first symptom was a second which did not disturb the patient, who frequently did not realize that a change of symptom had taken place. So far as he was concerned, he had "recovered."

Thus, there is a tendency to make speculations that may be perfectly valid but that partake too much of the parlor analysis that

is not only "wild" but tactless, as when a man recovering from an anxious mood buys himself a new necktie or a woman gets back into fine spirits by buying herself a new hat. Daily, in countless ways, each of us uses a list of activities during our work and play to discharge tension, to obtain satisfactions, or to strengthen our defenses. Undoubtedly these are models for the sort of recoveries from major difficulties that should be recognized as spontaneous improvement, some of which should be illustrated here.

The Glass Menagerie

One day a mother was giving me the history of her daughter, who had been brought to the hospital for treatment because of intense anxiety and obsessive fear that she might pick up a knife and kill her children. In the course of relating details about her daughter's upbringing, the gentle, soft-spoken, and sympathetic mother suddenly burst into tears. When I tried to relieve her distress over her daughter's condition, she replied, "Thank you! I know that you will do all that you can for her, but that's not what made me cry. I've cried enough over her, and I now have to tell you about myself." She then proceeded to tell the story that paralleled her daughter's history with a curious coincidence. Thirty years previously, after the birth of her second child, the same obsessional fear of killing her children with a knife had developed. She had had two more children subsequently, and she confessed that these two later pregnancies had been in some inexplicable way purposive attempts to get over her distressing symptom. Somehow or other, ten years after its onset, the symptom gradually began to disappear and in five years more it was completely gone. She knew not why.

To paraphrase an old story, I lost interest in the daughter, at least temporarily, and became most interested in the mother. She was quite willing to tell me as much as she knew and recalled about herself. Significant in her story was the fact that she had been reared in genteel elegance in a home in which high values were put on purity of thought, religious and civic activities and, above all, on the virtues of "being a lady." She became, in a way, an aristocrat of gentility and service, with the greatest control of all other feelings except those having to do with kindness and altruism. So solid were these attributes that there was no tinge

of martyrdom in her attitude. She was unaware of any conflictual difficulties throughout her life until the onset of her symptoms. However, in discussing the period of time between boarding school and her marriage, she said that she had often had fond fantasies of a career of her own. For a brief period nursing was attractive to her, but she admitted a little shamefacedly that she found the details a little "too dirty." Over a longer period of time she thought of becoming an actress; yet this was even less acceptable to her values than the profession of nursing.

No one ever knew that she had harbored these wishes. Her participation in church plays or "reading recitals" was the best substitute that she found for the longing to be on the stage. She apparently accepted with equanimity and good grace the impossibility of her fond desires. Even while speaking almost laughingly of these past hopes as childish and immature, she expressed curiosity as to why her symptom had not developed after the birth of her first child, a son, and had developed only after the birth of her second child, a daughter. But she quickly and lightly dismissed all this and went on to speak of her love for her children. Nevertheless, in her daughter's early years a hope crept in that the youngster might become the actress she never could.

On the first questions about the diminution of her symptom she stated that she had no idea what had brought it about. When asked if at that time anything had changed in her life, she said that nothing unusual had occurred. Numerous questions failed to elicit a connection with some change in her average routine, until I asked her whether she had taken on any new interests about this time. This struck a responsive chord and although she disclaimed any connection between this and her symptom, nevertheless, her face lit up as she related how on a shopping tour one day she was attracted by some small glass objects at a jewelry counter. The object which most caught her fancy was a small, slender, and delicate glass deer. She could not resist the impulse to buy it, though she chided herself for the indulgence. Little by little she began buying more such objects and expanded her interest in miniatures of all kinds. However, her chief interests were in delicate glass and china objects and in miniature paintings. When she had exhausted the antique and jewelry shops in her city, she began writing to antique collectors elsewhere for leads and soon became known as having one of the finest collections in that area. Fellow collectors from all over the country would drop in to see her collection, and this pleased her greatly.

Further questioning brought out a few other details. In a year or two after she began to take the collection seriously, she felt some concern that the objects might become broken if she left them arranged haphazardly on the mantelpiece and on the tops of various dressers and what-nots in her house. In retrospect, it now occurred to her that her anxiety about what damage she might do to her children began concurrently to diminish. She related that she had then had a glass case made in which she kept all her objects. Several years later when an out-of-town collector convinced her that she should put a lock on the case and insure her collection, she realized her tremendous emotional investment in her hobby. She followed her visitor's advice. Shortly afterward, she found that she was free of all concern about possible damage to her collection. I asked her then if this were about the time that she lost her obsessive fear of damage to her children; she said it must have been somewhere about that time, but assured me that she saw no possible connection between her collecting and loss of her symptom.

It must be granted that the collection of miniatures, especially the fragile objects that must be guarded and kept precious, became a means whereby this woman spontaneously cured herself of her obsessive fear of doing damage to her children. This is not a verifiable hypothesis, but it is the sort of evidence that we must rely upon in dealing with unconscious factors. The absence of any conscious hostile gestures on this woman's part and her denial of any regret that marrying and having children had interfered with her fantasies about a career gives substance to the idea that her resentment was strongly repressed and came out only after the birth of her second child. Moreover, she was able to prove to herself after she began her collection that she would never do any damage to any tender, fragile object (children). This proved to be an ego-strengthening device by which she could give up her symptom, since it was no longer necessary for her to be on guard against a hostile impulse. Again, this hypothesis is difficult to confirm, but a similar logic of the emotions can be verified clinically. I have often wondered how the giving up of her symptom may have related to the development of her daughter's similar syndrome, but on this point I have not even a speculation.

Private Kinsey Report

The second case is that of a young man, a divorcé in his thirties, who came of his own accord for treatment because of a chronic mild depression of three years' duration and a desire to find life worth while. A tremendous amount of acting out of all sorts of antisocial acts made the history a fantastic story.

His education had been punctuated by his being kicked out of one school after another for misbehavior. He began drinking heavily at the age of sixteen. Certain work activities bordered closely on the illegal. He failed in one business after another in which his father set him up. He was maneuvered into a marriage in the hope of "straightening him out," but this was terminated by divorce after his wife could no longer put up with his infidelities and cruelty. He had taken several "quick cures" for his alcoholism, but began drinking again as soon as he left the hospital. In a few serious automobile accidents due to his recklessness he had miraculously escaped serious injury. One striking feature, presented early in the course of the investigation, was that three years before coming to treatment he became aware of the fact that he no longer had any desire to drink. He had no idea why he had ceased drinking.

It was not difficult to formulate the structure of his personality during the course of investigation and study. His father, a wealthy, tyrannical, successful businessman, cold and unyielding, demanded the respect of everyone under his authority, including members of his family, except of his daughter, four years older than the patient. On her he showered affection and gifts lavishly and ostentatiously. To the patient the father was always rejecting; he gave only in return for good behavior and good deeds on the son's part. The mother was a submissive, overindulgent woman who could never refuse him anything he requested. The boy learned to pit his mother against his father very early in his boyhood.

The problem that the boy faced in his development was the difficulty in identifying with his cold, intolerant father, of whom he was afraid, whereas identification with his gentle, kindly mother meant to become feminine. One of his deepest unconscious desires was to obtain some manifestations of affection from his father. Yet, to achieve this meant to become like his sister; this in turn meant to be feminine and therefore had to be rejected. That his alcoholism had to do with his problem of

passive homosexuality and his desire to receive affection from his father seemed clear from the fact that it was his custom while drinking to seek out male companions and make them his "buddies." He was repelled from some of these associations when he was sober. Still, the question of why he had suddenly stopped drinking three years previously was unanswered from the preliminary formulations.

What later came out in the course of psychoanalytic treatment was a factor involving the substitute of a symptom, very much like that in the first case cited. Again, the patient was entirely aware of the substitute symptom but entirely unaware of the connection between it and his giving up alcohol. At the time that he stopped drinking, he had developed a habit of going to houses of prostitution, not for the purpose of intercourse but of getting to know some of the girls and inquiring about their personal lives. Since he was a charming, attractive young man, he had no difficulty in finding women who would readily tell him about how they became prostitutes, how they liked the work, and, above all, how they reacted and felt in sexual contacts with men.

This substitute activity of vicarious experiencing with women what they feel in intimate contact with men gratified his latent homosexual needs less destructively and much more successfully than did his alcoholism. Gratifying his wishes in this way made it no longer necessary to seek release from tension in drinking.

"I just made up my mind."

One day, after a lecture to a group of students on obsessions, compulsions, and rituals, in which I had especially stressed the difficulty of treatment of these symptoms, a student approached me to ask whether I would be interested in hearing how he had overcome a particular compulsion which had lasted about two years. I told him that I would be indeed glad to hear the story. We went into my office, and he told me his story:

At the age of thirteen he had a streptococcus sore throat which was complicated by nephritis. During the serious month-long illness he

almost died, and was aware at the time of the gravity of his condition. His convalescence was exceedingly slow, but eventually the grand day came when he was first permitted to get out of bed. He found himself surprisingly weak and in need of much support. As his strength increased he grew accustomed to hold onto chairs and tables as he took steps. Later he became aware that even though he no longer needed support of solid objects, he had a tendency to lean upon them and to hold on as he walked by. Then he noticed the need to touch such objects as he walked by them, especially solid, hard objects like chairs, door jambs, telephone poles, trees, sides of buildings, and so on. He looked upon this now, in retrospect, as an extension of his having to hold onto objects while he was relearning to walk. What distressed him about the symptom was the degree of anxiety he felt unless he touched an object as he walked by. He struggled with this for several years. Finally, around the age of sixteen, he said to himself one day that he would have to stop this foolishness. "I just made up my mind to stop it, and I did."

During class discussions this young man had advocated the use of "will power." He now cited his own case as an example of the possibility of conquering, on a conscious basis, difficulties of the sort that he had endured. I asked him whether he would mind going into some details about himself, to see whether we could uncover other factors involved besides his conscious will. He readily agreed and later I often wondered how much of what came out after that represented in some degree his penitent compliance after his initial outburst of daring to differ with me. Be that as it may, what he said is interesting enough to report, since it seems factual and illustrative of another mechanism in spontaneous recovery.

He said he was the youngest of three children and that his home was about the most typical and average American home he has ever known. His parents were both kindly and easy-going and his older brother and sister were remarkably good companions. He basked in being the baby of the family and had ambitions to become a sort of combination of his father and older brother. (The first session ended with his taking few pains to hide his triumphant feeling that he had demonstrated how he had managed to conquer a compulsion consciously.)

During the second interview he seemed a little puzzled and worried. Somehow the good explanations he had made previously did not quite satisfy him any more. He was thinking a great deal about his early ado-

lescence and had recalled some periods of concern and worry about himself, concern about his health at this period of time. I told him this was not strange in view of the serious illness he had had. But this was not what he was referring to. It now occurred to him that there was a period even before he fell ill when he worried about his health. I asked him whether he had any idea why. He then said he thought it was connected with masturbation. He had not thought so at first, but now it occurred to him that there was something to his fears about it.

Though sexual matters were not discussed freely at home, in case of need such matters were discussed in a matter-of-fact way by his parents. He recalled specifically that once his older brother told him not to listen to the poppycock he might hear around school that masturbation is harmful. He himself assumed a sort of adult attitude and nodded his head in agreement, but despite this reassurance he felt some guilt about masturbation. He then recalled also that on occasions during his serious illness and afterward, he wondered whether the illness had not been inflicted upon him as a punishment for masturbation. As he continued to talk, it appeared to him significant that throughout his convalescence and for some time thereafter he no longer masturbated.

All these details and more that he mentioned were by no means repressed and at no time during his talks did he have the feeling that he was uncovering something which had been unconscious. What had been pushed aside or isolated was the connection between this material and his compulsion. At this point he mentioned that the development of his compulsion might have been connected with the absence of his masturbation. This seemed fairly logical to him, although he in no way got any particular sexual pleasure out of the compulsion to touch. But the idea did remind him that he had spoken of how reassuring it was for him to touch these objects, that he did have a sense of their giving him some support. I said that when his faith in his good health had been shaken by his illness and his fears of masturbation, the compulsion may have served instead to reassure him that he was all right and not damaged. He shook his head and said he did not think this was so, but now something else came to his mind that fitted better than my explanation: around age fifteen or sixteen he began going out with girls and began to become stimulated sexually; one day he resumed masturbation. The masturbation, he said, did not give him any sense of damage, but a feeling of reassurance that he was perfectly all right. It was during this period of great reassur-

ance that he made his decision to stop the compulsion and about which he had said, "I just made up my mind."

Several things might be said about what happened in this instance of self-cure. The most important thing, in my opinion, was that he could not make up his mind successfully to stop his compulsion until he had developed sufficient ego strength by the reassurance he had received that he was all right, undamaged, and no longer needed the compulsion to defend himself in a magical way. The work of attaining the state of readiness to give up the symptom was done unconsciously.

Further questioning brought out some corroborative points for this thesis. During the two years after he had regained his full strength he still had doubts about the effects of the illness upon him. He started a campaign of sports activities in an attempt to emulate his older brother who was an excellent athlete. One of the real turning points in his reassurance was an event during summer vacation and just prior to the disappearance of his symptoms. He had gone away to camp and on his return to begin school he found he had grown an inch taller and had gained fifteen pounds. This sudden spurt was the most convincing evidence to him that he had maintained bodily integrity. It served actually as an ego-strengthening device so that he could tolerate any threat connected with the internal impulse which he felt was dangerous. The protective nature of the compulsion (what aggressive component was present I never discovered) was no longer necessary and could now be abandoned.

Again it seems worth while to stress that in none of the cases of spontaneous cure which have been cited did any matters of an unconscious nature come out. What is striking is that the connections of the events were unconscious, and our interpretation consists in the placing of emphasis on the interrelation and connection of the events.

VERY BRIEF PSYCHOTHERAPY

If we are mindful of the fact that the attempt at psychotherapy many years ago strongly emphasized the desirability of as short treatment as possible, and that it was done by the incantations of a medicine man, the laying on of hands, or mesmerism, it does not necessarily follow that our present interest in brief psychotherapy is a regressive trend. Undoubtedly most of the interest at present stems from economic necessity of treating as many people as possible who need help. Part of it is also a reaction against the air of doctrinaire righteousness with which some proponents of psychoanalysis haloed their science and technique. This attitude was aptly illustrated by a cartoon in *The New Yorker* about ten or twelve years ago. A couple in an automobile were beginning a drive. The woman, looking sharply at the man, says, "Remember we are in a hurry; we have no time for shortcuts."

The following examples corroborate the thesis that there may be many types of psychotherapies, but only one psychology that can explain all the psychotherapies. Nevertheless, it has been interesting to observe how different psychoanalytic therapists who reviewed the material in the following section emphasized the various aspects of the cases. One therapist emphasized the changes which had occurred structurally; another stressed the economic aspects. Some would attempt to explain all these changes in terms of their transference phenomena. This point is mentioned here by way of acknowledging the fact that the following interpretations may slight other factors.

To return to the theme of very brief psychotherapy, it must be said that this term is used not facetiously to mean the hurried making of ward rounds and greeting the patient with a smile and a "How are you?" but to describe examples of effective improvements accomplished in only a few interviews. To be sure, the question must be raised whether any cures were really effected. An attempt will be made to demonstrate that what was really accomplished was a change in the nature of the patient's symptoms. When his needs were met

his symptoms were changed from a distressing type to an unrecognizable and less distressing one. In a published report on a conference on brief psychotherapies of a few years ago, one advocate of briefer techniques remarked that he had successfully cured a case of impotence in one interview. The case details were not given. The following case is one of my own, in which the reader can decide the extent of the cure.

The patient, a business man of fifty-two, was referred by his family physician who was also his close personal friend. In making the referral the physician described the patient's impotence of two years' duration as clearly psychogenic, without evidence of the aging process or organic factor to account for the condition; he further had the opinion that it was definitely connected with the patient's wife's illness. The physician had also attended the wife, who was suffering a large emotional overreaction to some menopausal difficulties, and he surmised that the wife's illness had a psychic effect upon the husband. This tentative explanation seemed plausible enough and I anticipated finding a possible identification of the husband with his menopausal wife.

The husband began his appointment by telling me that he assumed his doctor had told me the nature of his difficulties. He volunteered that he had no idea what might be back of this symptom from an emotional point of view, since he was not aware of any conflicts as such; he was simply carrying out his physician's advice in coming to see me rather than coming out of any inner conviction. I asked if he knew why his physician had such an opinion, and he said that he did not. I then told him that his physician thought there was some connection between his wife's illness and the development of his own symptoms. This was news to the patient; he seemed surprised. When I asked him to tell me some details about his marriage, he launched into a paean of praise of his wife's virtues, her gentility, fragility, respectability, and passivity. Yet much of his praise was in negative terms to the effect that his wife was never a nag, not ambitious, not extravagant, not sloppy or disorderly, and so on. Their sexual relations he considered satisfactory until the development of his impotence. It was true, he brought out in response to question, that his wife had had little or no satisfaction from their sexual relations in the past and he had tried not to "bother her" very much, but when he did bother her, she would usually acquiesce dutifully, while he was careful

to be gentle with her. This gentleness she, in turn, appreciated greatly and thanked him for it on many occasions.

In the light of what he had just said I asked whether his physician's evaluation of the present situation might not have some validity. He replied, "Of course, of course, I see what he means now, and as a matter of fact, it is quite true that since she fell sick I have been extraordinarily careful not to hurt her and I don't want to. Now I've got to be all the more careful." I then asked him if he would be too uncomfortable to give me some details of what happens when he attempts to have intercourse. He became rather uncomfortable and squirmed a little, but I pressed him for details. Then he related that she noticed on several occasions that he was restless and having difficulty going to sleep, and at such times she would make the following remark—or something similar—"Charlie, if you want to, it's all right with me. I can stand it." Asked what he thought of this attitude on his wife's part, he immediately began to defend her, excusing her because of her illness, and blaming himself for his brutish nature. I then remarked, "I wonder whether you ever gave some thought to the possibility that she doesn't want any sexual relations with you any more than you do with her. Do you think that's possible?" His face lit up immediately as he said, "I think you have something there." Then he reconsidered, shook his head, and said that, on second thought, he doubted that there was very much to the idea.

For the rest of the interview he was considerably more troubled and ill at ease than at the beginning. He answered questions abruptly and I wondered whether I had touched too quickly upon a tender matter. He did not keep his second appointment. Just before he was to come I received a message that he was detained in business and would call me for another appointment. He never did.

About a month later I met the referring physician, who asked me what I had done to his friend. I told him I didn't know because I had not heard anything from him. He laughed and proceeded to tell me that I must have done something because the man's potency was restored, and he had begun a sexual relationship with a younger woman (this the physician knew from the young woman, who was also his patient). The patient had also resumed sexual relations with his wife, who consulted the physician because the resumption of intercourse was rather painful to her. When the doctor said he would ask the husband to attempt to refrain from sexual relations because of her pain, she asked him not to do

so because she was so happy that her husband's sexual desire had returned that if she could be of service to him she would not even think of mentioning the pain that she was enduring. She was happy in being a dutiful wife. And so, the physician said, he mentioned none of this to Charlie. Thus, the reputation of another young psychiatrist increased on the strength of a dubious technical device.

It is not difficult to formulate from the little evidence at hand something of the dynamics involved. From the excessive protestations of tenderness it was clear that the patient had been covering up hostile feelings for a long time because of what he felt were denials of sources of gratification to him. His conscience, however, did not permit him to acknowledge them openly to himself. The brash hypothesis in the form of a question that (in its conscious intent) was largely exploratory effectively removed, because of my authority in the situation, his feelings of guilt, or at least some of the feelings of guilt about hurting his wife.

From what was known about his character structure, details of which will not be gone into here, it was very clear that sexual gratification and hostile impulses were pretty close together in this man and that he had found in his extramarital relations a way of releasing hostility toward his wife and also permitting himself direct expression of it by his sexual relations with her. By this maneuver the patient achieved at least the aim and goal that he had set in therapy. Economically, it might be said, the energies which were bound by inhibition were thereby released. Dynamically, it can be said, one symptom simply replaced another. Only the more direct expression of the hostile impulse became permissible in regard to his potency.

Reverting to an earlier remark about a newer demonology, many concepts stem from several sources in the course of modern theoretical systems and have been condensed during clinical observations into a general theory that if one detects hostile impulses that are inhibited or repressed, their release will effect some sort of improvement. Part of this formulation stems from the old concept of abreaction and part from economic aspects of the theory of personality.

Whatever the source, the general tendency to assume that hostility is almost always present and that if the patient can be enabled to express this directly, an improvement will take place is noticeable in some therapeutic devices. Of course, this is not always true. People are afraid of other things besides their own hostile impulses. Yet there are times when the dynamics involved repressed hostility and if it can be effectively and safely released in treatment, improvements are sometimes dramatic. Cases of this type are not uncommon in the literature.

Let us now consider another brief treatment not for the dynamics alone, but because the peculiar setting for the improvement illustrates how much more is involved than simply abreaction.

A patient of mine asked me to come to see her aunt, who had gone into a depression. When I was shown into the aunt's bedroom, I saw a woman in her late sixties standing rigid with her arms akimbo and staring straight ahead. She refused to look at me. I told her who I was and that her niece had asked me to come to see her. She turned her head toward me and glared. The small bedroom contained but one chair, a rocking chair. I asked her if she wouldn't sit down. She turned her head away, stared out of the window. I sat down on the bed. She immediately looked at me angrily but again turned her head away. I attempted to make conversation by asking her how she felt and what had happened to upset her so. Did it have anything to do with her younger niece, Jackie? She did not respond. I tried to make myself comfortable and took out a cigarette and lit it. There was no ashtray in the room. I looked around for one and finally ended up by putting the ashes in my hand. Meanwhile, I tried to establish some communication with her. Moving around on the bed, I drew up one leg to make myself a little more comfortable and touched the bedspread with my shoe. As soon as she noticed this she wheeled around and dropped her arms. She stamped her foot, clenched her fist, and yelled, "Get out of here! Get out!" I picked myself up and got out. By that night she had recovered, and for at least a year (to my knowledge) she remained well.

At first glance it seems as though what happened was relatively simple. Here was an angry woman holding back rage. When afforded an opportunity to express her anger at a convenient object, she released it

and recovered from her depression. But there was much more to the case.

I had the advantage of knowing a good deal about this woman before I ever met her. Her niece, who had been in treatment with me for several years, had told me that the aunt was the only one of a family of five girls who had never married, because of her strictness and puritanism, my patient thought. A prim, proper, dictatorial woman, full of moralistic preachments, she neither smoked nor drank and never permitted anyone to smoke or drink in her house, which she kept spotlessly clean. For the past fifteen years my patient had lived with her aunt whenever her work did not take her to other cities. The one other occupant in the house was a younger niece whose mother had died when the child was eight. Circumstances were such that it was best for the maiden aunt to take over the young girl's care, a fact which both welcomed.

The aunt was overprotective and strict but gave the young girl a great amount of affection. As a result of having this child to rear a little softness had crept into her, but she was unyielding on the point of how the girl should be instructed and what her habits should be. She violently opposed my patient's being in treatment, which she claimed would distort her mind. Sometimes her opposition became so vehement that my patient would have to move out for a few days; then the aunt would soften and welcome her back, trying each time to get my patient to promise that she would give up treatment. The patient stubbornly refused to do so. Part of the aunt's opposition was the fact that I was a man, and this fact played an important role in the patient's treatment and in her aunt's attempts to keep both nieces from having contact with men.

About three weeks before the onset of the episode I have recounted, the niece, Jackie, now nineteen years of age, had gone to visit relatives a few hundred miles away. Soon Jackie's letters began to drop off, and during a week of silence the aunt became somewhat distressed. Finally, there came a special delivery letter telling the aunt that she had met a young man; that they had immediately fallen in love and were going to marry; and that she knew the aunt would be happy because her fiancé was a wonderful boy with a fine job and lovely parents with whom they were going to live. When my patient came home from work she found her aunt standing and staring and not talking. She neither ate, drank, nor slept that night; at most, she paced around a little. When the niece returned from work the next day and found her aunt unchanged, she called me.

My patient reported that after my visit her aunt for several hours

kept up a violent tirade against me, against Jackie's young man, and against all men. Then she calmed down and proceeded about her daily routine. My patient promised she would never see me again. She did continue seeing me, but did not tell her aunt, who continued to believe that by this promise she had won some sort of victory over men.

It may be argued whether this was a true depression or not, and whether what I did was correct. In retrospect, I do not recall whether what I did was with full conscious appreciation of the significance of this artificial situation. But it should be stressed that obviously my provocative behavior—intruding into her home, sitting on a bed that had not been sat on for years, smoking a cigarette in a house where smoking was strictly forbidden—so irritated the woman that she attacked me directly, thereby releasing all the pent-up fury of her longstanding hostility toward men. It is even more significant that she took out on me her rage toward the niece's fiancé who had robbed her of the only thing in life that had given her pleasure. My patient's concession (never to see me again) became a sort of triumph wrested from the pathetic situation and was apparently sufficient to reinstitute the older woman's defenses and keep her intact.

ADDITIONAL THEORETICAL CONSIDERATIONS

On one occasion while I was a resident in psychiatry, I came, very troubled, to my chief to consult him about things that were happening in one of my cases. I was worried because the patient was taking a dislike to me. In my inexperience I did not realize the significance of what was going on. All I did know was that I did not like it. I wanted my patient to like me and felt that liking was an absolute requisite for successful treatment. My chief listened patiently to the details of what had happened and reassuringly told me, "Don't worry about it; people get well for one of two reasons—either to please their doctor or to spite him." These words have stood me in good stead for many years, even though one must rec-

ognize that too much of what is talked about and written about as a transference cure has to be broken into its various component factors to be intelligible.

To say that a patient gets well to please a doctor does not tell the whole story. If pleasing a doctor is involved, then the patient must be grateful for something. There are still other possibilities. Giving up a symptom to displease or spite a doctor implies that the patient by his flight into health proves the doctor wrong. It must be that, in one way or another, an interplay of dynamic forces operates between these individuals. In the treatment of some cases it is clear that the patient gets well because he is afraid to displease the doctor; he fears the therapist more than he can express because he needs him. Endless are the intricacies of the patient-therapist relationship in the simple and the complex forms that repeat previous life patterns. Different authors vary considerably in what they believe operates therapeutically in a transference situation. To some, it is a relatively simple matter that if repetitious behavior comes out in the transference and is pointed out to the patient, someday—tomorrow, next week, next month, or next year—the patient will finally get the point and change his behavior. Other authors, to whom this formulation is much too simple as an intellectualization, emphasize that reliving and re-experiencing in the previous pattern are needed for any degree of conviction and change to take place. Neither explanation is sufficient.

Rather than become involved in the theoretical complexities of what occurs in the therapeutic situation, let us begin by considering relatively simple factors. Although much has been made of dividing psychotherapy into such types as repressive, exploratory, and supportive, it seems better for purposes of this presentation to ignore these descriptive criteria and approach the problem from the viewpoint of the patient's needs.

Probably the simplest example of meeting a patient's needs is the instance in which difficulties clear up when the patient receives some magical or primitive treatment. Even though we may not consciously remember, our bodies do remember how an ache or a bruise

was miraculously cured by being held in a parent's arms and having the injured part rubbed or kissed. On these old magical devices rest numerous physical therapies now utilized by the chiropractor and the masseur, who know intuitively that direct contact with the body has a comforting and relaxing effect. The same is true about medicines whose magical effect operates through the deep expectation that something bad is present in the body and that good medicine can neutralize it or get rid of it. In all these devices there is a hidden element so frequently not recognized in that the suffering patient participates, by partaking of the medicine or the magical gesture or action, in something of the greatness and the power of the authoritative therapist. By partaking of this magic, the patient is strengthened.

So too in psychotherapies, in which words and gestures are the chief means of communication. Some persons have improved or have overcome their symptoms when apparently not much has happened except that the patient acquires the terminology of the therapist. Sometimes in further extension, the patient begins to use whatever thinking habits the therapist reveals. This incorporative act strengthens the patient better to meet his difficulties. Though fewer than in years gone by, there are still instances in which spurts of improvement occur when the therapist simply helps the patient formulate his problem in terms that he can handle. This may be the main factor in the intellectual-insight therapies.

I recall the pleasant surprise, which at first puzzled me, when a troubled patient was pouring out his heart and I interjected a question, "Just when did this anxiety begin?" The patient seized on this, "That's what I've got—anxiety—that's what it is." Soon I realized that this word enabled him to put a label on his difficulties so that he could handle his vague, disturbing tension. "Anxiety" was now something that could be understood and spoken about. He could convey just what torment was going on inside him. This magical word permitted him to participate in the power and ability of someone whom he felt to be stronger and more capable. He gained strength thereby. (The day in which one can surprise a patient by

the use of a simple and descriptive term may be over. Patients often come to a psychiatrist with full knowledge of the terminology, dynamics, and correct formulation about their difficulties.)

Much of what has been criticized in the past as being an intellectual type of psychotherapy and therefore ineffectual actually does help some people. Some patients use their intellectual abilities as defenses, especially in analytic treatment, but in nonanalytic psychotherapy, especially of the unsophisticated patient, an intellectual understanding does have a concomitant emotional correspondent, namely, the identification with the stronger therapist, which is often of great assistance, even if it also is a resistance. Emotional needs, too, can be satisfied in this way. It is sometimes amazing, despite the meaningless content of the material that is interchanged, how meaningful the relationship between patient and therapist can be therapeutically. For example, some individuals who had suffered repeated rejections in their earlier lives and some who even had a gift for provoking rejection from others do remarkably well in treatment and overcome their depressive symptoms and anxiety simply because the therapist was patient and uncritical, gave them time, was consistent, and remained unprovoked.

The following case illustrates several of these points.

A small, bespectacled young man of twenty, timid and passive, came to the clinic because he was worried about losing his mind. He was blocked in his speech and only with the greatest of difficulty got out what was troubling him. Slowly, with effort and perspiration, he told that he was failing miserably in a difficult course in a technical college. At night when he would attempt to study he would find himself reading the same paragraph over and over without the slightest comprehension. Not only had he lost his ability to concentrate, but he was becoming forgetful, he could not sleep, he had no appetite, and lately a voice had begun to terrorize and frighten him, saying to him, "You're a bad boy. You're no good." He interrupted his description with repeated pathetic pleas, "Can you help me, doctor? Please help me. You must do something to help me." His need for help was so intense that it was obvious he had to be given immediate reassurance. I told him definitely that I thought he

could be helped if he would continue to come to the clinic. I was sure that he would get well.

My initial attempts to formulate what was going on in his case suggested that there must be some unconscious wish of his to do something bad (probably something sexual), which he could not tolerate, and that he was decompensating under the force of the impulses. Possibly his mildness and meekness covered over his strongly repressed hostile feelings, which it might be necessary to uncover. But above all, he impressed me with his ineffectuality and the lack of substance and strength. There was not much to him. He would have to be nursed along before he could stand any investigatory probing.

The interviews, first twice a week and then less often, had for the first few months the same unvarying pattern. Sensing that some information was desired about his life, he would begin bits of historical details, descriptions of his life at home and at school, but he would soon pass over into desperate pleas for reassurance and immediate relief. Little by little, he revealed the detail that he was an only child, that he lived with his parents in the poor section of the city. His father was also a small, meek man, who worked about half the year in the garment trade. The father's routine was unvarying, whether he worked or not; he left the house about seven in the morning and returned at five, ate his supper, read the paper, and went to bed. He spoke little to his son and less to his wife. In the slack season he walked the streets, sat in the park, occasionally found an odd job. These times were especially difficult; the patient's mother would berate her husband for improvidence, then desperately apologize, and say that she was going out to find work herself, while the father would usually shrug his shoulders in helplessness.

Often when the young man declared he would stop school and find himself a job, his mother absolutely refused him permission, telling him pointedly that he was the only thing she had in life, that he was going to make something of himself, have a trade or a profession. It was clear from the boy's description that he could not answer the forcefulness of her argument when she asked him, "You want to be like your father? Do you want my life to be meaningless? Do you want the clothes I could have had, the furniture I didn't buy just to keep you in school to mean nothing?" When I tried to test out the patient's evaluation of the effect of his mother's ambition on him, he would insist that she was absolutely right, she was doing the best thing for him.

The chances of his recognizing a relationship between his present failure and the burden placed upon him seemed nil. His resources were very low (he had made no friends in school, considering himself too inferior to dare associate with his classmates), and he accepted his inferiority as justified and irreparable. His only recreation was occasionally to take walks or to read the *Reader's Digest* because he considered the jokes amusing. He had no interest in girls and no sexual drive.

Because he repeatedly requested help, and there could not be aroused in him the slightest amount of curiosity as to what was going on, I began to give him direct advice.

"I'll tell you what I want you to do tonight. When you sit down to study, I want you to outline the first paragraph you read. Don't go on to the next one until you have outlined it and understand what it means. If this doesn't work within a half hour, I want you to get up and not try to study. Do something else. Walk over to the Center and watch the basketball game, or read a magazine if you can, but don't study unless it begins to make sense."

I asked him to bring his textbooks. We went over difficult passages. I showed him how to outline material. I reviewed with him details of events that happened in school, how he might have discussed a problem with the instructor a little better. There was hardly an item of his activity that we did not eventually go into, from matters of how to tie a necktie or pick a worth-while movie to how to use an encyclopedia as a reference.

Little by little he improved. He was still not curious as to what had happened to him, and attempts to stimulate psychological interest fell on deaf ears. He began to report increasing improvement, a little more ability to concentrate, more cheerfulness and freedom from anxiety. Finally, one day he told me with embarrassed pride that he no longer heard "the voice." I told him this was fine and then asked him if he could tell me a bit more about the voice. He said he could not identify it at all, except that it was a woman's voice, definitely not his mother's.

One day I told him that he would have to stop treatment soon, that I was going into military service. He was crestfallen and agitated. He wondered how he could get along without me. I told him that he definitely could do without me. If he would keep in mind the things I had told him, he would not lose what he had gained. He was skeptical that it would work. But he did report in subsequent interviews that when he felt himself getting into a tight spot he would first imagine what I would

do in such a situation, and then go ahead and do it. When we finally parted he was almost in tears. I asked him to write me. He promised that he would. He wrote from time to time letters full of gratitude; occasionally I would receive a carton of cigarettes as a present. Gradually the frequency of his letters diminished, but I heard that he had passed his examinations, that he had been granted a license, and had obtained a very good job. Two years later he wrote that he was opening a shop of his own. He was feeling fine and had been doing well. He expressed his eternal gratefulness.

Four years after I had last seen him I happened to be back on leave and met him on the street. We went into a near-by drugstore to have a coke and he told me of his good fortune, sprinkling his appreciation of his present blessings with much thankfulness to me. His business was doing well. He was giving money to his mother, and had begun going out with a girl whom he would like to marry if she would have him—the type of girl he knew I would approve of. Suddenly I said that I would like to ask him a question. He became a little flustered but said that he would answer any question I asked. I asked whether he had any idea why he got well. He became so embarrassed that I immediately told him he need not answer if the question upset him, but I was curious about why it bothered him so much. He protested that since I wanted to know, the only decent thing was to tell me the truth. He then said the following:

“I’m very much embarrassed because I lied to you and I never told you that I lied, but I know you’ll forgive me. Do you remember one day when I told you I no longer heard the voice? Well, in a way it was true, but in another way it wasn’t true. What actually happened was that since then I have never heard the voice that bothered me, but from then on, I keep hearing your voice and you tell me, ‘You’re all right, you can do it. You’re a good boy.’ And I think that has kept me going.”

THE DEFENSE STRUCTURE IN PSYCHOTHERAPY

It is highly doubtful that there will ever come a time—except someday when all psychiatric conditions may be treated pharmacologically (and this, too, is highly doubtful)—when diagnostic and formulative considerations of psychiatric problems can

ever be so systematized that a very definite and specific indication for saying exactly certain words or behaving in a certain way is in order. The high degree of variability in the individual reaction pattern almost automatically precludes such possibilities, and in addition there are complications that arise from the individual reaction pattern of individual psychotherapies. To cite one example of an apparently simple situation: A therapist asks the patient, "Why did you do that?" The patient may react in one of several ways. He may sense the therapist's words as a query directed toward asking the observant part of himself to look into the motives for a given act. On the other hand, the patient may sense an accusatory or disciplinary tone in these very same words and may react either by feeling attacked or by accepting the implied admonishment.

It may very well be that the patient's internal situation does not determine the way he reacts but that a reality factor may be involved; that is, the therapist may intend his words to have one meaning or another, depending upon his own mood or intent. This relatively simple situation thus includes a minimum of four concomitant possibilities of the attitudes and intents of the two persons involved in therapy.

Let us extend this simple example into a more specific instance which arises frequently in therapy. The patient comes to the first interview manifesting a considerable amount of anxiety of such intensity that it precludes investigatory work. Clearly, the intensity will have to be diminished before the patient will be able to look at himself at even a short distance, let alone attain that ideal situation of permitting himself to feel and observe about himself at the same time.

The point is how to achieve this diminution of anxiety and permit some investigation of etiological factors. The possible settings in which such a situation may be attained are already so numerous and complex that it is impossible to determine any one word or phrase that will universally allay anxiety. If one requests of the patient, "Tell me about yourself?" or "What happened to upset you so?" the patient may respond with diminution of anxiety if he

can simply tell his story. Some patients, however, will take these neutral questions to indicate the therapist's uninterestedness. Such diversity of reactions has been observed by most workers in the field.

Most observers of "therapeutic processes" rather generally agree that the technique of obtaining an associative anamnesis is the most fruitful and understanding of what is going on in the case. Yet, not infrequently a patient resents this method of investigation because it seems evidence of lack of interest in the patient and of greater interest in the therapist's own needs. What actually seems to happen in some of these latter instances is that the patient is looking for evidences of strength in the therapist, for something to lean on, or for something to guide him. If the therapist reponds solely with questions which go from one point to another only as the patient sets the direction, anxiety is increased, if anything, since the patient is left too much at the mercy of his own impulses and reactions. He is looking for control.

On the other hand, that the patient will often have a remarkable diminution in anxiety if the therapist asks him questions systematically and chronologically is evident: "Where were you born?" "Did you go to school?" "How did you get along there?" and so on. Something within some patients responds to this orderly procedure; they have the impression that the therapist knows what he is about, that one can be secure in his hands. This may occur in spite of our own present-day sophisticated attitude that such ways of obtaining a history is amateurish and naïve. Still another factor may be implicated in the latter example, namely, that the examiner's distant attitude may very well assure the patient that he need not fear any anxiety-provoking involvement. These examples are cited primarily to show the complexities of treatment situations, including many dynamic factors not obvious at the time, which can best be evaluated in retrospect. Our hope is, of course, that knowledge of what is going on at the moment may be of greater help.

It seems already clear that no single answer will suffice for the changes that take place in the patient in psychotherapy. One significant pattern in modern types of psychotherapy that is of great

importance lies within the implications of some of our treatment methods. In the course of an investigatory psychotherapy, one aim is often the uncovering of past traumatic episodes, frustrations, or inadequacies and of ways of meeting past situations. The patient thus learns to achieve in some way an understanding of his previous pathological reaction pattern and achieves thereby some degree of belated mastery over his impulses.

It frequently appears that the patient gains insight and strengthens weaknesses in his ego structure because of acquisition of new knowledge, learns how to postpone obtaining gratification, and learns how to make compromises and valuable identifications with the therapist. Yet, underneath all this is often detectable the unconscious use of projective devices that seem to be large factors in the improvement that takes place, of which surely the patient and often the therapist are not aware. This is not to be criticized as poor therapy or poor technique. Sometimes devices of this sort are indicated.

A normal model for the devices now being emphasized can be found in the almost universal tendency to disavow impulses or derivations as being ego-alien. "I don't know what came over me" or "Something happened to me." These are not uncommon examples of the ways in which one has a tendency to deny or project an internal impulse. The same mechanism is observable in many somatization reactions, in which difficulties are projected onto an organ or onto the body. (Not all psychosomatic conditions follow this pattern, of course. A good many are paranoias, in which the patient considers his body or part of his body as a persecutor.) The intuitive awareness that this mechanism is most important in some individuals is undoubtedly present in physicians who themselves have such mechanisms, as can be seen by the frequency with which they tell a patient that his functional condition is due to disorder of the bowel or stomach and then prescribe against this organ as if it were an ego-alien enemy. Many patients have already formulated their conception of illness in this way and readily accept the medicine offered, again receiving relief and feeling stronger since they now have an ally.

It seems that similar technical devices are used in many psychotherapies, especially those of an exploratory nature, in which the difficulties and defects lie in the past and are to be uncovered. The patient may effectively and compliantly begin to project his difficulty onto one parent or the other or onto the general childhood situation, under the guise of working through a transference attitude, which in itself may be having some effect. No small measure of relief comes in those individuals who can successfully project onto something in the past. Admittedly, only a small group of patients can do this effectively. A good many of those who come into treatment with strong feelings of inferiority successfully displace the blame for the condition upon a previous situation and emerge somewhat stronger, since the therapy in a way absolves them from a sense of guilt and of their own inadequacies. In an analytic situation this should never be permitted to stand; in a nonanalytic therapeutic situation, this is often a great achievement and should be left unresolved. In the case of the inadequate young man whom I described earlier, it could be seen that he had no tendency within him to blame his difficulties upon his parental handling. He resisted any effort on my part to help him do this. However, these projective tendencies can be discovered rather quickly in most of this group, who are quite willing to have them strengthened. Whether they should be strengthened or not is a matter of correct evaluation and clinical judgment.

It is now possible to discuss the matter of the concept of strengthening the defenses by first making an analogy with what happens from the physical point of view in the presence of organic disease. Although the regulatory processes of the body operating under the homeostatic principle try to maintain an equilibrium between conflicting forces, some of these, from a valuative point of view, are called defense processes. For instance, in an area where pathogenic bacteria begin to have toxic effects, the body responds by attempting to wall off this locus with phagocytic bodies and fibrocytes. (Let us ignore the teleological aspects.) It is nevertheless a fact that the walling off of this locus and the formation of an abscess do in a way protect the rest of the body from invasion. However,

because of its space occupying properties and pressure upon vital centers, the abscess in itself may be pathogenic. If it is now surgically treated, the pathogenic elements in the abscess itself are removed.

Thus we see that, depending on numerous factors—the type of organism, size of abscess, its position and its duration—a process initially defensive and protective in nature now has become pathogenic and may again be healed. Again, depending on numerous factors, what remains, how much scar tissue and its interference with function, are variable.

A similar process goes on psychologically wherein defense mechanisms can become pathogenic. Though for many reasons beyond the scope of this presentation the analogy is not perfect, it is nevertheless the ultimate aim of ideal treatment, for both the physical and psychological defenses, to remove the defenses that have become pathogenic, leaving as little scar as possible.

This is one of the aims of psychoanalytic treatment which, unfortunately, cannot be applied to as many cases as might be desired. Even though, theoretically, every psychiatric condition should be amenable to psychoanalytic treatment, we know that this is impossible because of the general fixity and immutability of certain defensive patterns. Nevertheless, a certain fluidity in these patterns remains, so that some changes can be effected.

Illustrative of the point of increasing the pathogenic defense and at the same time changing the content of the symptom so that it no longer bothers the patient is the following case.

An instructor in a near-by university wrote to the clinic and stated that he had referred a young man in his late twenties for psychiatric help. The reason for referral was that the young man's behavior was becoming more and more peculiar in classrooms and on the campus. The possibility of getting psychiatric help had been broached to him. The instructor went on to state that for some time now the patient's dress was becoming more and more bizarre. One day he would wear green trousers, a yellow shirt and sandals; the next day he would come in a business suit jacket and jodhpurs, but no tie. He had been observed in

classrooms and in the library laughing softly to himself. In class he was argumentative with his instructors, liked to trap them in fallacies in thinking, and engaged in polemic discussions to the disgust of most fellow students. At times it had been necessary to threaten him with dismissal from classes if he did not stop being so disruptive. His classwork, however, was brilliant, and the referring instructor admitted that the student undoubtedly knew more about several subjects he was taking than did his teachers.

A few days after receipt of the letter the young man called to ask for an appointment. He was seen by one of the social workers, who noted the following pertinent data about him: the patient's appearance was impressive; he had an ungainly disproportionateness to his body; he was unkempt; and his features were coarse. The most striking thing about him was that he had one eye missing and that he wore oversized dark glasses which did more to draw attention to the missing eye than to cover up the unsightliness.

His reasons for coming to treatment did not at all coincide with the instructor's complaints. He wanted treatment (and was grateful that someone had finally suggested it) because of strong feelings of inferiority, especially those having to do with women. He had strong sexual urges and an aversion to going to prostitutes. If he dated a girl on the campus, she never went out with him again after the first date. He was sure this was because girls disliked his ugliness and were repelled by his appearance.

He then went on to explain what a terrible cross his ungainliness and his lack of one eye were for him to bear, expostulating psychoanalytic theories as explanations for what was going on within him. True, he had had a miserable existence. He had been deserted at birth and was reared the first two years in a foundling home. Then, until the age of sixteen he lived in a succession of boarding homes and orphan homes. He lost his eye in an accidental fall when he was about five. Although various agencies had provided him from time to time with a prosthesis, he rarely wore it because it was a nuisance. A mixture of reasons was responsible for his not staying long at any one place. Foster parents never liked him enough. They were people interested not primarily in him but in obtaining the money paid for taking care of him. He admitted that perhaps he himself had contributed in some way to their not liking him by his obstreperous and unruly behavior, but this was clearly of secondary importance in his mind.

At sixteen he struck out on his own, doing all sorts of jobs, from unskilled labor to going to sea. He really never considered himself as settled down in any way until the first time he went to sea. There he was told in no uncertain terms by other sailors that he was disliked because of his argumentative nature, and he was practically ostracized. He began to spend more and more time reading and considered himself quite superior to the others on board ship because of his greater knowledge. When he hit shore again, he began to go to school to complete his education. When he ran out of money, he went to sea again. His intellectual interests were literature, philosophy, and psychology.

In presenting his philosophical ideas, which he insisted that the intake worker listen to, he really evolved a cosmic theory of grandiose proportion, encompassing all of the world's knowledge. His theory indicated the trends that the future must take, as shown by his analysis of the past. This led him on to point out his great superiority over his classmates and instructors. Moreover, in presenting so much of these data to the intake worker, he attempted to jockey her into positions of stating whether she agreed with him or not, whether he was not right on this point or that.

The worker's attitude led to his insistence that he see a psychiatrist and not a psychologist or social worker, since he was sure he needed a person of considerable experience, not a beginner, to handle his problems. The implication was clear that he considered anyone less than an experienced psychiatrist beneath him, and since he was stipulating this as a condition for continuing his visits to the clinic, it seemed correct to yield on this point. To have done otherwise would have meant becoming involved in polemic discussions that would only continue the pattern by which he became embroiled with most people.

In his first appointment he was told that I knew something about him from his initial interview. I asked him if there was anything special he cared to add. When asked to tell more about himself he forthwith proceeded to give what might have been a prepared demonstration of the psychological nature of his difficulty. He thought his troubles dated back to his childhood, especially from the time he lost his eye. Though he recalled relatively few details of his childhood at that time, he was certain that he was at that time in a strong oedipal conflict and that the accident had been unconsciously purposive on his part as punishment. He should therefore be analyzed in order to resolve this pattern.

More specifically he meant that his argumentativeness and provocativeness with people were a continuation of his hostile impulses against a foster father for the purpose of inciting the father to punish him. He had also considered the complications in his presentation; for instance, the loss of his eye had stirred up castration fears in others, who reacted to this by shrinking away from him. This was especially true with women who refused to have anything to do with him. As evidence for the constructions he had made about himself, he thought he recalled episodes in which the foster mother with whom he was living at the time of his accident had shown great fondness for him. He had desired to become very close to her and get into bed with her. The foster father must have sensed this. Yet he modified his remarks to the point of admitting that he really had no actual memory of this event, that the memory of this entire period of his life was vague and indistinct. He was, nevertheless, firmly convinced that something of this sort must have happened to him.

Evidences of the effect he had upon people consisted of noticing, of late, that when he was talking with a girl, she would stare at the eyeless part of his face and become overwhelmed with anxiety. In several instances, after he had talked with a girl she was not in class the next day. Though not absolutely certain, he was fairly convinced that she was not in class because the emotional trauma of looking at him had precipitated castration anxiety, which manifested itself by the beginning of a menstrual period and cramps, thus keeping her from coming to school.

He ended the discourse by asking me if I did not agree that this was a plausible explanation of things that were happening to him and if he did not need analysis in order to uncover the original traumatic memories that might free him from the necessity of repeating this pattern. By this time it seemed clear that the patient's needs for his intellectualization were very great and that care must be taken not to rob him of this defense. Granted that there was little likelihood of this, there was greater danger that, in the course of the interviews, failure to agree with him might make him feel antagonistic to me. Effective disagreement, no matter how subtle or gentle, might make him suffer a loss of self-esteem. I therefore told him that his formulation might be entirely correct, but that if it were so, then perhaps it should show itself by way of derivatives in his everyday life, about which I knew very little.

I asked him to tell me, as an example to sustain his thesis that could be investigated, just what happened when he went out with a girl. His

story then was one of how stupid girls were to be interested in frivolities and chit-chat, how his attempts to engage them in serious conversation about philosophy, literature, and science led nowhere. As he talked I could very well imagine any young woman, however intelligent, becoming bored with his monologue. Again, his discussion went straight from the topic of what happened on a date to further psychological theories. It was easy to speculate on how necessary it was for him to demonstrate to me that he could meet me on common ground, that here was one field in which he could be my equal, if not my superior. Discussion of this aspect of the problem and indeed of the transference elements in this case were never brought up with the patient.

Continuing his thesis, the patient then went into a discussion of the stupidity of some of his instructors. Interspersed in his vivid and excited description were numerous hints of their antagonism toward him because of their recognition of his superiority. His description of this phase of his difficulties rather typified the one that paranoid patients often make, which is a convenient distortion of facts for them when they present themselves as being masochistically inclined and provoking punishment (rather than as paranoid and hostile). Again, to point out the reality factors to him seemed entirely too premature, since his degree of conviction was so great that he might have interpreted any attempt at reality testing as another attack. At the end of the appointment I told him that what he had said sounded plausible enough but that I was dissatisfied with some of it and thought that in the future we might work out together some of the missing links.

At the beginning of the second interview I told him that I had been thinking about what he had told me about himself. An idea had come to mind that I wanted to present to him. Had he considered the possibility that, with all of the history of neglect in his childhood, his provocativeness might have an explanation other than that of wishing punishment? It seemed to me that he was making at least one phase of his problem too complex.

A simpler explanation was that he was constantly looking for love and affection, which he did not have, and that he was putting his worst foot forward all the time in order to make doubly sure that in case he was accepted it would be really for himself and not for any ulterior reason. He mulled this idea over and thought it sounded fairly reasonable but not deep enough. I asked him why he had such a need to complicate

things and not to accept simple solutions as answers. We discussed this for a while, and finally it came out that perhaps this need was in line with the fact that he considered simple answers as rather beneath his intellectual ability and prowess, that he wanted to complicate them to demonstrate to himself that he could handle complex situations and indulge in mental gymnastics beyond the ability of ordinary people.

I then tried to demonstrate to him that his desperate need for affection was really behind his provocativeness. Why should a fellow so intelligent make it so difficult for himself? I pointed out what he had done in his interview with the social worker and what he had already done with me, trying to put both of us on the spot, forcing us in a way to accept him and his ideas; that he gave me the impression that he made all people uncomfortable in this manner. He seemed to accept this tentatively, still feeling a need to show me that this was not the only factor. I agreed that it was not the only factor, but went on to ask him if it might not be that he did not wear his glass eye for a similar reason, in order to make it more difficult for people to accept him. This impressed him. I asked him if his dressing bizarrely might not also be of the same origin. He agreed that it was possible.

This last point is worthy of some discussion. It seems quite inaccurate to present this explanation to a patient as a reason for bizarre behavior which really is in large measure due to regressive and disintegrating factors. But had I then pointed out that his peculiar dress and habits were due to fragmentation, no matter how neatly couched the phrases, they would have conveyed the idea to him that he was psychotic. He was in no position to accept this idea; therefore, neither the disintegrative or regressive aspects of his behavior were broached.

The three subsequent interviews were in the main concerned with something he had worked out himself. He was considerably subdued, less argumentative, and, possibly, a little depressed. He began to indicate how his provocativeness was a cover for his intense need to be near people, how it defended him from being rejected. He would rather establish no contact in the first place than establish one that would be meaningful and then lose it. To avoid repeating what must have been a painful childhood pattern, he kept people at a distance by his behavior. However, while his general attitude had softened, his specific attitude toward teachers and competitive classmates was still unchanged. He still had a necessity to demonstrate his greater intellectual abilities. Now he rationalized this on

the basis that truth was truth; he could not permit misstatements and inaccuracies to go unchallenged in class discussions.

Again, disregarding the possible transference significance of his remarks and being aware of many megalomaniacal elements involved, I decided to attempt another approach toward this symptom. I told him there was no doubt about his intellectual superiority and his ability to think things out clearly, and yet there was one disconcerting thing about his attitude—that he still felt the need to prove his genius. It was almost as if he were trying to convince himself rather than anyone else, since his attempts obviously did not have too much effect upon his colleagues. If he were really convinced of his superiority, it behooved him to be content with knowing it himself without having to demonstrate it to others. This theme attracted him immediately and was discussed with numerous variations. He could listen to someone talk and think quietly to himself "You dope, you," and not have to challenge what was being discussed. He felt secure in himself. There was detectable a small element of pride that he knew a good idea when he saw one, and therefore he accepted what had been pointed out to him.

I heard later from the referring source that his behavior and dress in the classroom had changed remarkably. A year later the patient came to the clinic to see me, one of his purposes being to ask me if I knew where he could get a job. He had married, and his wife was pregnant. His manner was changed to a considerable extent. His whole bearing and attitude were a distinct improvement over what he had presented when he first came to the clinic.

It is proper to emphasize one aspect of what happened in this case: the support of a defense as a therapeutic device. Here the patient's inferiority was defended by his deep conviction of his superiority, approaching megalomaniac proportions. This defense was further sustained by me when I presented to him the possibility that an even higher order of superiority would be to remain silent, safe and secure in a deep and real conviction of his superiority, and not have to engage in polemics. Of course, this was not the only thing that happened. Along with this support other factors were operative: some identification with the therapist and the gaining of insight as

to the nature of his need for affection, against which he was defending himself by making it difficult for anyone to like him.

It is exceedingly doubtful that any essential change took place in his character. That he lost his symptoms is clear, including some that he was not aware of. It is my impression that he may later have difficulties because of weakness of his defenses against his own hostile impulses.

AN UNUSUAL CASE

The mode of presentation of material herein may be criticized from several points of view. There is no doubt that the case illustrations are a little unusual, but they have been chosen because they afford opportunities for sharp illustrations. Likewise, valid criticism may be made of the point that a systematic correspondence between diagnostic entities and therapeutic aims has not been constructed. This is true. Yet, though there are some features specific for depressions, for instance, in which one looks for a sense of loss of elements of introjected hostility, and though in schizophrenia certain recurrent syndromes lead logically to certain technical aims, I find myself, for purposes of these presentations, unattracted to such an approach. I have always found it more fruitful to give case illustrations as the didactic device next best to actual case supervision and the acquisition of clinical experience.

What a meaningful clinical experience actually entails is in large measure a recognition of the relative strength and weakness of various drives and defenses. (That intuition plays a role in these evaluations there can be no doubt.) The experience accumulated through numerous errors and occasional successes teaches one to gauge when one individual cannot tolerate, at a given time, the investigation of his hostile impulses while another can; when an hysterical patient may tolerate a considerable amount of ventilation about his anxiety; and when a schizophrenic may need a great deal

of reassurance and strengthening before etiological factors in regard to his anxiety can be touched. Any attempt, such as the above formulation, to generalize and to establish formulas for the indications and contraindications of use of specific therapeutic devices is too mechanical. At least I am incapable of proceeding in this manner. Therefore, another case, which illustrates several mechanisms worthy of discussion and exemplifies a combination of many of the points mentioned previously, will be presented.

The patient was a twenty-one-year-old woman, tall, dark, rather good looking, and attractively dressed. She was referred for treatment because of an overwhelming fear that she might stab someone in the back. Her symptom was of eight or nine years' duration and had waxed and waned during this period of time, on occasions being intense and at other times being practically absent. She had been married for two months, and ever since her marriage the fear had increased until at the time of referral she was almost in panic.

Difficulties arose at the beginning of the first interview. She burst into tears and began to demand that something be done immediately to cure her, declaring that she had been led to believe by the referring physician that something could be done very quickly. Her expectation was that a magical cure of some sort or other could be effected. When I asked her to tell me the details about the duration of her symptom, she countered by saying that she had been present in the office when her physician had called me about her and that there was nothing else to tell. She wanted to know how long it would take her to get well. As gently as possible I told her that she gave me the impression that she was expecting something magical, that she could help me to help her if she gave me details about herself.

Because of the intensity of the anxiety I thought it desirable to attempt to put some distance between the patient and her symptom. I proceeded systematically to obtain historical details. It was then, in response to repeated questions, with the patient volunteering practically no information otherwise, that the following came out. She had been born and reared in the San Francisco Bay area. She had a brother nine years older and a sister three years older, all in good health. Both parents had been born in Europe, had come to the United States in their adolescent

years, and had been married here. Her mother was illiterate, hard working, kind, interested only in her children's welfare, constantly denying herself any pleasure or luxury, fanatically religious, and very superstitious. When the father was out of a job, the mother would take work at night as a scrub woman in an office building to help support the family.

In Europe the father had begun training for the priesthood, but after several violent arguments with priests had fallen out with the Church. From that time on, he was a militant atheist, so much so that he kept the children from receiving any religious education. He had no patience with the mother's superstitions or religious opinions. The religious issue rarely came up at home because the mother yielded to the father's superior intellect and forcefulness, although she did so pathetically and sorrowfully.

The patient had finished high school and had been supporting herself since her graduation by doing clerical work, which she continued to do after her marriage. She was in love with her husband, and this was the first time her fear of plunging a knife into someone's back had taken a specific person, for now she was afraid that she might hurt him. Previously the object of her fear was no one in particular.

She recalled the onset of her symptom at about the age of twelve, while she was listening to a radio dramatization of a girl who stabbed someone in defense of herself. She could recall no details of her life prior to this event. I remarked that this was very strange. She said it was true, nevertheless, but on continuing to speak she did recall an episode which must have happened when she was nine, a violent argument which had taken place between her father and her brother. Her father ran into the kitchen yelling, "Where's a knife?" The implication was that he was so angry that he would kill his son.

I brought the patient back to telling me more about the way she lived at present. She told me of her working and living conditions, and it became clear that, because of her economic situation and the necessity of her remaining at work, I could see her only twice a week. I arranged to see her on her afternoon off and during the week end. This I did for ten interviews.

At the beginning of the second interview the patient was still very much upset because I would make no promise to her as to when she would get well. I reminded her that her symptom had been present for nine years and that I could not work magic. She responded by reminding me

of her mother's superstition and went on to elaborate (the first time that she had spoken in any way resembling a spontaneous manner) that her mother believed very firmly in superstitions about going under a ladder, planting by the moon, black cats, broken mirrors, and never having anything in threes. She went on to say that her mother had told her that when she was pregnant with the patient a snake had chased her down the street. The patient half-seriously and half-smilingly asked if this might have anything to do with her case. I asked her why she smiled; it was as if she did not believe it herself. She said that her father was always making fun of such things and that on occasions he would get very angry about superstitions.

I then recalled what she had told me about the conflict between her mother and father in regard to religion. She said that she was always a little troubled by it. On the one hand, she had the feeling that her father was right, because when he was not angry, he seemed so sensible and reasonable. He would remind the children that their mother was ignorant and did not know any better and would admonish them to read and study and find out the truth. In spite of this she was not quite sure that something might not happen to her because she was not a practicing Catholic.

Here in this reference to the Church came the first clue to what might be utilized in helping the patient. This tentative formulation came to mind. The patient, right after her marriage, being called upon to muster her feminine identifications, had as a result a great intensification of her symptoms. It is not unlikely, therefore, that something about femininity was dangerous to her. Moreover, since her mother's superstitions were frightening and her father's rationalism comforting, the latter might be utilized in treatment if it could be divorced from the violence that accompanied his anticlerical attacks. With this in mind, I purposely developed the aim of aiding her identifications with the more intellectual father.

Since she had just mentioned snakes, I asked her if she, like her mother, was afraid of snakes. She promptly responded that for years every night before going to bed she had looked under her bed for snakes. She could not bear to look at a snake or even handle a book in which she knew there was a picture of a snake. She knew that this was silly and ridiculous; nevertheless, she was overwhelmed with anxiety.

I asked what else she was afraid of beside snakes. She replied, "Oh,

lots of things—rats, worms, spiders,” but it was clear that these did not bother her as much as did the snakes. I then hazarded the first interpretation to her. I told her it seemed to me that she was afraid of the damage to her body that a snake or a worm or a rat might do. Immediately she said, “Why, I have always been afraid of that, ever since my accident.” “What accident?” “I told you about my accident.” “Please tell me again, I don’t recall.” She then told me that when she was about five she was walking on a picket-fence, she slipped and straddled the fence, and a picket went into her perineum. She was ill for some time.

Here is one clinical point and one technical point that are worthy of mention. Her telling me that she had mentioned the accident, whereas she actually had not, is quite typical of certain hysterical patients who spare themselves the painfulness of recall of traumatic events by feeling as though they have always been aware of the episode and have already related it. A second and more important point in this connection was that the patient accepted the implication of my interpretation fairly well, since I was drawing emphasis not upon her intent to do damage to others but upon her fear that damage might be done to herself. People in general will more readily accept interpretations of not being loved enough or of fear of loss of love or damage than interpretations that they do not love or that they want to do damage.

When the patient came for the third interview, she remarked spontaneously that she was feeling somewhat better, but she did not know why. Nothing came to her mind to talk about and she waited for me to ask questions. I then asked her to describe her personality. With a mixture of a little pride and a little shame, she told me how she liked everything to be in order. When she took off her shoes, they immediately had to be side by side. No ashes could be left in the ashtrays. Dishes had to be done immediately after meals. The same thing occurred in her work. If she had to make one erasure she would do an entire page over.

She was asked what would happen if she let some of these matters go. She said it would bother her very much. She would be afraid something would happen. I remarked that this reminded me of her mother’s attitude about her superstitions, that she had to play safe by having everything in order. I suggested to her that she might try letting ashes remain in the ashtrays, letting the dishes go until later in the evening if she felt like it, thus proving to herself that nothing overwhelming would really happen. She doubted that she would give it a try; she might, but she was

not sure. As she got up to leave, she said that there was one question which had been bothering her for a long time and she wanted to know if I could answer it the next time she came. The question was, "What's a criminal?" I told her we would discuss it.

In the fourth interview, without asking her how she felt or what had happened, I recalled the question to her and began giving a superficial explanation of the various types of criminality, leaving it rather incomplete, and then interrupted myself to ask her why she was so concerned about this. Roundabout questions finally drew out that what she was concerned about was that she might lose control and kill someone. A little later it became more clear that her concern about this was really again a sort of magical force, that an impulse would come out of nowhere, overwhelm her and force her to do something against her will.

I thought it timely to go into some superficial psychological theory and explain, reassuringly, impulses of behavior. This satisfied her a great deal. The impression I obtained from the nature of her satisfaction was that I was not only giving her information, but I was also demonstrating to her that there were reasons for behavior, that behavior could be understood, and that it could be talked about and even controlled. The aim of this attempt was in line with her seeking refuge in intelligence and rationalism, as opposed to the panic that magic, superstitions, and uncontrollable impulses had for her.

I ended this hour by reminding her that I was impressed more with the problem of her fear of damage being done to herself than of her fear of doing damage to others.

In the fifth interview the patient was very much improved. She volunteered the information that she had stopped crying, that she was now sleeping all through the night and was not panicky; but she was still not certain about her improvement, since there had been temporary disappearances of her symptoms in the past. Again she had nothing more to tell me and waited for me to say something.

At this time I summarized matters that we had discussed before: that she was afraid of something happening to her, something doing damage to her body, and that she was playing safe with numerous superstitions, compulsions, and rituals to guard herself against some sort of sudden attack—attack from snakes, knives, and like objects. (A systematic brief summary is at times useful in helping patients strengthen intellectual defenses and helping them with a sense of control. This aids a patient in participating

with the therapist's experiences. Some patients respond as if they had now been given weapons against enemies, both external and internal.)

The patient's response to the summary was rather startling. She said that while I was talking she had remembered something; she was not sure whether she had mentioned it to me in the previous interviews. When she was about five or six (she could not be certain whether it happened before the episode in which she hurt herself on the picket fence or not), her brother had attempted to rape her. She said she had been terribly frightened. When I asked her if she knew what she was really frightened of, she said she had no idea. It was only a very great terror that he was going to hurt her. She added that she also remembered being frightened with her first menstrual period. She had a vague fear that she had injured herself in some way. When I asked if she had other sexual fears, she said that on her wedding night she was terribly afraid that her husband might hurt her. Also, the first time she took a douche, a wave of anxiety came over her.

In the sixth interview, the patient stated that she could now at least think about the idea of hurting someone without becoming upset. She felt that this was an improvement, but she would like to be free of the idea altogether. It still bothered her that she was drawn back to thinking about this fear, as if she were tempted and fascinated by the idea. She was better in other ways too; she found that she could now permit minor errors to occur in her work and not have to do an entire page over. Likewise, at home she was much freer and relaxed; she was not attempting to be orderly and compulsive.

When I asked how she was getting along with her husband, she smiled and said, "Fine." But when she got down to answering specific questions, she said that intercourse was still frightening to her. She was frigid, but that did not matter.

What developed on further questioning was that she really had not the slightest idea what went on during intercourse, revealing a typical hysterical pseudo stupidity about her own anatomy and the simplest psychological matters. She said she had never asked any questions about it, had not even been curious about it. Suddenly she said, "It would be a good idea to know something about these things," but she did not have the slightest idea how to go about getting information. I then recommended to her one of the popular books on anatomy and physiology and suggested that she read it.

In the next interview, she came radiant and happy. She said that she was feeling fine and that everything was going well. She brought along the book I had recommended. She had read it during the week end and had many questions to ask. The questions began with many trivial details about anatomy and physiology of the eyes and digestion and soon veered to some of the actual mechanics of intercourse. While I was making explanations, using the pictures and text in the book as a reference, she was paying more attention to my face and expressions than she was to the book.

What I also did during this hour was to foster intellectual aspects and further identification with her rationalistic father. At the end of this hour she was asked, in view of her improvement, whether she might consider the possibility of stopping the interviews. But she felt that she should continue the interviews for a while longer.

In the eighth interview she said she was not as well as she had been previously; she felt a little depressed. She had no idea what bothered her, since the fear had not recurred, nor even ideas about it. Suddenly, in the course of discussion about her work and life at home, she interjected a question, "Is it possible to think about something and not have to do it?" I gave her numerous illustrations of how this was possible, but she was dissatisfied with these. Finally, she asked me pointedly, "Can you think of putting a knife into somebody and feel that you don't have to do it?" I told her that I could. That made her feel a lot better, but the temptation of the idea and the fascination still puzzled her.

I spent a considerable period of this interview giving numerous examples and analogies differentiating thinking from action. It was interesting in this connection how the patient's concern was a classic struggle of the obsessional neurotic.

In the ninth interview, a week later, the patient said she was practically well. She was a little concerned about having a baby. She wanted a child, but she had some concern that if she had a child, her fear might come back. I asked her whether she had given any thought to the possibility of reading some books about babies and childbirth or of being around babies of her friends to test out the idea. She said this had not occurred to her. I then asked her what she felt had helped her most since she had been seeing me. She promptly replied that she had received the most help from my telling her that I could think about stabbing someone in the back and not have the impulse to do it, and, second, that I had given her help in the assurance that she could figure things out for her-

self and not have to be afraid. Much of the time was spent again in summarizing for her the material that had been gone over in the past.

We made another appointment for a month later. She came, saying that she had never been so happy, that she was getting along splendidly with her husband, that things were going well in her work, that she was not worried or bothered by the impulse to stab someone in the back, and that she felt reasonably sure that her difficulties would not come back. Her attitude toward me was considerably more distant than before. There were less naïveté and a larger display of sophistication—not too convincing, but adequate for her.

About ten months later I received a telephone call from her. She was quite upset and anxious. Her symptoms had not returned, but she was greatly distressed over an argument she had had with her mother-in-law, who had turned out to be an ardent member of one of the fundamentalist Protestant sects and who had provoked arguments with her son and daughter-in-law, especially about their failure to read the Bible and go to church. I asked how her husband felt about these matters, and she said that he agreed with her, but that he did not want to make an issue out of the matter, since, after all, it was his mother who was involved.

I asked the patient whether she wanted to come in to see me. She said she was sure that if she could talk with me on the telephone she could get the matter settled. Finally we got down to where I asked her pointedly what was really bothering her. Why wasn't she letting all this talk go in one ear and out the other? In a much more subdued tone she replied, "I know you think this is silly, but I just wanted you to tell me that there is no such thing as hell where people go for their sins." I replied, "Of course there isn't. You know that just as well as anyone." She answered, "Yes, I know, but I thought I'd feel better if I heard you say it too." I heard no more from the patient until three years later when I received a Christmas card and a brief note saying that she was getting along very well and had had no recurrence of her difficulties.

From time to time in the course of presentation of this case, I have mentioned the important therapeutic devices employed in treatment. Several factors involved fostering the identification with a more intellectual father, who was more rational and less ruled by superstition and magic than the mother. There was also the device of permitting the patient to use me as a model to test out her fears, of permitting

her to participate with me in both aggressive and sexual elements in the transference, but at a distance. In this way the patient apparently did achieve some sort of belated mastery. The devices also afforded her the opportunity to project the cause of some of her difficulties onto the traumatic episodes of her childhood. This afforded her a little relief in the sense that she could feel as if she were not responsible for the evil impulse within her. Quite important also was the demonstration to her that what she feared she might do actively was actually a derivative of her fear of what might be done to her passively.

This last point deserves a small elaboration, in that treatment here and its successful conclusion in symptomatic relief are noteworthy for the absence of any investigation of her own aggressive impulses. What she was told about her fear of active aggression being based upon her fear of passivity is only an incomplete truth. Her identification with her violent father was never touched upon, and, I believe, correctly so, as long as the aims of treatment were those that had been determined in the first hour, a matter of individual clinical judgment. I myself had felt no inclination to go into the aggressive elements here, nor would I have done so unless the patient were in a more intensive psychotherapy or in an analytic treatment.

It is likewise noteworthy that the direct transference factors were not discussed in spite of the fact that they were obvious and that there was some transference acting out, which the patient fortunately used as part of a learning process. The transference was not interpreted because I had the impression that it would better fit the therapeutic plan to keep it in the background. How the transference factors were managed in the treatment of this case does indicate how the patient's identification with the therapist permitted her to gain strength against her internal enemy.

To attempt to summarize now some of the principles that have been interwoven with these cases would not be consistent with the attitude and spirit of this presentation. However, there is one final

point that should be emphasized. What has been presented here in this unsystematic way has touched upon technical problems in the light of economic, structural, and dynamic factors. These are points that may very well come up from time to time in the course of psychoanalytic treatment. The chief difference between analytic and nonanalytic therapies, however, is that it is doubtful whether a therapy directed toward meeting derivative needs or strengthening pathogenic defenses can be truly called psychoanalytic. The absence of a thorough working through or analysis of derivatives and what amounts to the arbitrary settling—whether justified on clinical grounds or not—for goals set by the therapist characterize this type of psychotherapy as distinctly different from classic psychoanalysis.

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Directive and Eclectic Personality Counseling

Frederick Thorne

Frederick Thorne, who is recognized as one of the leading authorities in psychotherapy and who has a special interest in the place that directive psychotherapy occupies in the psychotherapeutic field, has an unusually broad and varied background. He is editor of the *Journal of Clinical Psychology*; diplomate in clinical psychology; psychiatrist with the Veterans' Administration and in private practice; Professor of Psychiatry, University of Vermont Medical College; author of *Principles of Personality Counseling* and of more than fifty papers in scientific journals; and holder of M.D. and Ph.D. degrees.

Dr. Thorne developed his "system" of directive psychotherapy as a result of his concern about the sudden popularity of Rogersian nondirective method to the exclusion of traditional methods. He was concerned not so much about nondirective methods as about the uncritical enthusiasm and apparent cultism associated with this new development.

Directive psychotherapy, as seen by Thorne, is not considered a new school or a complete system in itself. Rather, he sees it as an eclectic approach involving a number of different therapeutic methods which may be utilized in various combinations for dealing with specific types of personality problems. Also, Thorne believes that the critical factor is not the method that is used but, rather, the skill with which it is used. His concept of directive psychotherapy also implies a straightforwardness—the shortest path to the goal desired.

He believes that the well-trained psychological scientist is the person best equipped to provide whatever degree of direction is necessary to catalyze therapeutic processes. Until the disturbed person demonstrates his ability to regulate his behavior in a socially acceptable manner, he should be subjected to varying degrees of direction or regulation from the environment—in this case the therapist.

Directive and Eclectic Personality Counseling

THE PURPOSE OF this chapter is to review the basic principles of the comprehensive system of directive psychotherapy and to make a definitive statement concerning the eclectic orientation that is the basis for the proposed system of practice. The primary motivation is to present a comprehensive system of counseling and psychotherapy that will integrate and relate the positive values of newer viewpoints with traditional methods. This system should be more than a compilation of isolated facts and should be based primarily on the objective foundations of experimental psychology. Its basic orientation would be determined by a detailed system of psychopathology derived from a more comprehensive method of personality analysis than had ever been attempted before. Through modification of the classic psychiatric methods involving (a) Kraepelinian descriptive classifications, (b) psychobiological longitudinal studies, and (c) psychoanalytic depth analysis, the new method would seek to evaluate systematically and, if need be, to redefine *all known important personality traits* by the eclectic utilization, according to their indications and contraindications, of all available methods.

Although the designation of a system of psychotherapy by the term *directive* was undesirable, the choice of term was determined partly by the conviction that the sudden popularity of Rogersian nondirective methods to the exclusion of traditional methods was a dangerous development both for the profession and for the student. This apprehension arose not so much from the nondirective methods per se, which are admitted to have great value when used judi-

ciously and properly, as from the uncritical enthusiasm and cultism associated with the new development. It appeared that there was definite need for a comprehensive system that would relate directive and nondirective methods in their proper perspective and emphasize the values of eclecticism in clinical science.

ORIGINS OF DIRECTIVE PSYCHOTHERAPY

Terminological Considerations

The term *directive* seemed especially appropriate to designate a system of therapy based upon a formal plan for the identification and modification of etiological factors in maladjustment. It is presupposed that persons representing themselves as psychotherapists have training and experience to enable them to utilize adequately all known methods at the proper time. Possession of such training and experience, which is more than may be expected of even the most intelligent and best-informed layman, places the basic responsibility for the *direction* of all stages of case handling with the therapist, even though he may choose to delegate some portion of this responsibility to other persons, including the client himself.

In our opinion the possibility of a completely nondirective method is nonexistent because of the very nature of the therapist-client relationship. The client comes to a therapist, who is considered to be of superior experience and training and who is thereby enabled to establish a relationship of dominance through prestige; the therapist determines the method to be used; and what happens in the therapeutic relationship must be evaluated not only in terms of what the therapist thinks he is doing but also in terms of what the therapy means to the patient. We are dealing not with a dichotomy of directive or nondirective, but with a continuum involving various degrees of directiveness, on which nondirective methods may be said to be at one extreme, along with other "passive" techniques.

The concepts of directive and direction also imply straightforwardness, that is, straight, leading by the shortest way to a point or

end. *Directed* movements of an organism are those which are observed to be related to a specific stimulus or goal. *Direction* is an attribute of behavior indicative of specific function and variously expressed in terms of needs, drives, goals, purposes, and other concepts descriptive of integrated behavior. One of the principal characteristics of the maladjusted or disordered person is the inability to resolve problems unaided. Although self-direction is the highest democratic goal and evidence of integration, the maladjusted person either asks for help spontaneously or is induced to do so for his own good. Until such time as the person demonstrates his ability to regulate his behavior within the limits of what is socially acceptable, he is subjected to varying degrees of direction or regulation from his environment.

The general rule may be stated thus: *The need for direction is inversely correlated with the person's potentialities for effective self-regulation.* In other words, the healthier the personality, the less the need for direction; the sicker the personality, the greater the need for direction. It is to be assumed that the well-trained psychological scientist is the person best equipped to provide whatever degree of direction may be necessary to catalyze therapeutic processes by the shortest method. Judiciously utilized, psychological knowledge may lead to specific action in facilitating curative processes in much shorter time than might be accomplished by the client working by trial and error, even assuming that homeostatic resources would be sufficient. Although we recognize the dangers of overregulation and overinterpretation in cases of mild personality disorder, it is our opinion that the therapist is obligated to protect the interests of the client when the client is unable to do so himself and that failure to institute the indicated degrees of direction in more serious cases may constitute malpractice.

The significance of these facts is that the therapist is supposed to *direct* the over-all details of handling the case according to tested scientific procedures, whether he is utilizing nondirective methods or authoritarian methods in an institution. Training and experience should enable the therapist to judge when to be directive or when

to be relatively nondirective. The validity of the results will be determined by the skills with which any method is used in accordance with etiological diagnosis and the indications of each individual case. Thus, *the critical factor is not what method is used but rather the skill with which it is used.*

We do not share the ideological bias of many nondirective therapists who hold that all that is directive is bad and all that is nondirective is good. In his basic text, Rogers (12) attacks directive methods by criticizing the most crude and unacceptable forms of directive methods and implying that all directive techniques are subject to the same handicaps. Directive methods can be fairly judged only when they are employed with maximum skill; it is unjust to base criticisms on atypical examples that would be condemned by all experienced directive therapists. Long before the development of nondirective methods, psychoanalysis had demonstrated the errors of overinterpretation, too much leading, crude interference, and other pitfalls of the beginning counselor. The nondirective viewpoint appears to have gone to the extreme of rejecting direction in any form simply because it has frequently been misused.

Blain (3) has pointed out that effective therapy frequently involves a compromise between what a patient sincerely believes he wants and what he needs in accordance with the most objective judgment of the experienced therapist. Although it is theoretically desirable to place major dependence upon the growth principle and homeostatic processes, as emphasized by Rogers and many others before him, there are many cases in which the client's resources and growth potentialities are so deficient or damaged that adjustment without outside help and direction is impossible.

A further application of the concept of *directness* is illustrated in our tendency toward a systematic application of the *law of parsimony* (Lloyd Morgan's canon). In contrast with the current popularity of psychoanalytically oriented approaches, which seek to discover latent meanings, symbolism, unconscious complexes, and other depth processes in personality, our viewpoint is that primary consideration should be assigned to direct interpretations of manifest behavior ac-

according to the principles of scientific psychology and especially the laws of learning. Much is lost by failure to make the simplest possible interpretations and also to proceed in the most direct manner consistent with the needs of the client. It is an axiom of directive therapy, as well as of nondirective, that the less said by the therapist the better.

Directive psychotherapy accepts the concept of *distributive analysis and treatment* developed by Meyer and described by Diethelm (5). The distributive principle assumes that it is most effective to budget time and energy during the treatment process, giving major emphasis to trends that appear to be most etiologically important. Instead of spending hundreds of hours more or less passively exploring the channels taken by the client, considerable saving may be accomplished without violence to the client-centered principle by directing the course of treatment along what may seem to be the most profitable lines. In addition to etiological studies that explore the developmental history of the person, assessment of learning ability and accomplishment in all areas of activity is also important. Directive psychotherapy is especially concerned with maximizing the self-regulatory functions of personality with emphasis on self-control and conative life. Further, certain phenomena that are usually denied or ignored in traditional psychology—including the study of the nature of consciousness, nonconscious mental functions, volition, suggestion, hypnosis, deviant personalities of all types, and other phenomena that have important significance for psychopathology—should be explored.

The directive principle that intellectual resources constitute the highest potentialities for adaptation in the organism and that therapy must be realistically distributed to deal with both affective-impulsive and rational-intellectual factors as they are encountered in the individual case is based on the important distinction between primary and secondary etiological factors in maladaptation. Etiological factors may be identified as precipitating, predisposing, or perpetuating.

Recognition of the need for maximally potentiating intellectual

resources of personality in problem-solving behavior has important implications in both theoretical orientation and practical applications. If human behavior is determined by unconscious, instinctual, affective-impulsive components in personality, it follows that maladjustment is caused by mechanistic, physiological factors over which a person can exert little conscious, voluntary control unless his growth resources or homeostatic tendencies are sufficiently strong to effect a cure. On the other hand, if the idea that rational-intellectual factors may supersede and control impulsive behavior is accepted, then the normal person may be expected to achieve some success in solving problems by conscious use of his intellectual resources.

This point of view does not necessarily involve the postulation of such mental functions as will or volition. On the contrary, the acquisition of self-regulatory abilities is regarded as a function of past training, usually by directive methods, since few individuals are gifted enough to work out optimal methods by themselves, and a trial-and-error process would not be economically desirable even if it were possible. Important areas of maladjustment are regarded as being caused by failure to *learn* to solve such problems by the use of intellectual resources. Normally this learning would take place in early life, thus preventing maladaptation. Since the basic factor in most psychotherapy is commonly admitted to be re-education, it therefore follows that the treatment process is essentially a training situation.

Even in unfavorable conditions it is occasionally necessary to resolve emotional attitudes before training may proceed. If latent, sub-conscious, un verbalized affective-impulse reactions are important determiners of behavior, so are acquired intellectual traits and attitudes operating on manifest conscious levels. The goal of therapy is to replace emotional-impulsive behavior with deliberate rational-adaptive behavior based on the highest utilization of intellectual resources. To accomplish this may require the use of many directive techniques over and above the simple nondirective handling of emotional reactions, which may be understood as simply the first step in therapy.

The Basic Method

The theoretical foundations for directive psychotherapy are derived from a survey of the historical development of clinical science, through which the principles and methods which appear to be valid for clinical psychology are carried over. By utilizing standard techniques of description, classification, statistical evaluation, and integrative interpretation, directive psychotherapy attempts to discover the causal conditions that result in maladaptation and then to utilize specific treatments for each pathological condition. Unless comprehensive etiological studies are carried out with every case, it is difficult to understand how any objective evaluation in case handling may be made. However, this unending search for the causation of morbidity must never be allowed to conceal the basic objective of satisfying the needs of the client.

Gregg (7) states a cardinal axiom: The human organism involves such a complex relationship of constituent parts that one part cannot be modified without affecting all others; that, therefore, a given result comes usually not from one cause but from a combination of causes, sometimes a sequence, sometimes a constellation or pattern; and, similarly, that a given cause has not one but many results, sometimes in sequence, sometimes in pattern. In such a complex situation, it is inevitable that a wide armamentarium of therapeutic tools will be needed and that each tool must be used as skillfully as possible in line with a valid knowledge of what each tool can be expected to accomplish.

One of the most important contributions of Adolf Meyer's psychobiological approach to personality was his recognition that pathological processes of different types may involve personality functions as a whole or in parts. By careful appraisal of all the known functions of personality, it becomes possible to identify areas of dysfunction, to postulate etiological factors, and to outline specific plans of treatment. The psychobiological approach is genuinely eclectic in the sense that it seeks to assess all known functions, assigning proper weight to dysfunctions of each in the longitudinal study of personality.

The system of directive psychotherapy that is to be presented here is theoretically oriented upon psychobiological approaches to the whole organism, with perhaps more emphasis on rational intellectual components than on affective-impulsive, since we believe that the highest potentialities for adaptation are related to the maturation and effective utilization of the higher cortical functions.

The developmental phenomena associated with the maturation of the cerebral cortex are now well known and may be summarized as follows: Although the biologically more primitive affective-impulsive components of personality are constantly operative throughout life, the maturation of the cortex with the development of the higher mental functions results in the achievement of rational intellectual control through cerebral inhibition of lower functions and the acquisition of tremendously enhanced powers of learning. The dominance of the cerebrum over mid-brain and hind-brain functions is achieved very slowly and only incompletely in the average person; thus, learning self-regulation, making the most of one's resources, and achieving insight into the meanings of behavior and life in general are parts of a very gradual process.

The theoretical foundation of directive psychotherapy is derived from an integration of the principal contributions of the main schools of psychology. From behaviorism comes a major emphasis on the role of learning and of environmental stimulation in the development of acquired patterns of behavior. Experimental psychology of the traditional type contributes important information concerning sensation, memory, association, physiological reactions, and other relatively elemental phenomena. Gestalt psychology is important because of its emphasis on the whole and its detailed studies of the perceptual process. Psychoanalysis is important in its emphasis on depth psychology and its developmental studies of the affective-impulsive life. Finally, hormic psychology contributes the stimulating point of view that organic phenomena are largely determined by purposive factors as yet not clearly understood.

Following the psychobiological approach, which assumes that the psychologist will have detailed and extensive training and experi-

ence in the basic sciences of anatomy, biochemistry, physiology, and pathology, as well as in normal psychology, directive psychotherapy depends for its validity upon the psychological sophistication and broad perception of the person who attempts to utilize it. The better oriented the clinician is to the psychological sciences and to life in general, the better able is he to avoid the pitfalls that are recognized as inherent in any active (directive) method. Any method is only as good as the skill of the clinician makes it.

THE NATURE OF DIRECTIVE PSYCHOTHERAPY

Directive psychotherapy is not a new school of psychotherapy or a complete system in itself; it is simply an eclectic method suitable for dealing with specific types of personality problems. We have always regarded the attempt to establish new schools of clinical practice as artificial and harmful to scientific progress, since the only truly scientific approach is the eclectic method of utilizing all known methods according to their indications and contraindications.

Our own approach to counseling and psychotherapy is based on the contention that all effects of psychotherapy must be explained in terms of psychology of learning. All methods of psychotherapy may be classified under either of the two general headings: *establishing suitable conditions for learning to take place* and *providing suitable training situations* according to the psychology of learning, so that reconditioning actually takes place and is translated into action. It is very important to understand this distinction. Under the heading of establishing suitable conditions for learning, we would include many of the techniques of psychoanalysis and nondirective therapy that are intended to create rapport, to analyze early childhood conditionings, especially of traumatic emotional nature, to deal with emotional repressions and blocks to self-expression and growth in the present, and generally to unlearn older maladaptive patterns and to gain insight into how we got that way.

But analysis and emotional release and the acquisition of insight

are often not enough and do not inevitably result in cure. It is then necessary to undertake the second part of therapy, which involves an active reconditioning process that must not be considered complete until insights are actually translated into action. Much of the psychotherapy of the past has failed because the therapist and client did not work hard enough in practicing newer patterns until they were actually mastered. In other words, it is necessary not only to know what is the matter and what to do about it, but also to work hard until newer styles of life are mastered and become an organic part of the client.

Directive methods are based on the hypotheses that the learning of newer adaptive patterns must depend upon maximum utilization of intellectual resources in personality. To gain or regain mental health may be regarded as an exercise in problem-solving behavior in which learning or relearning are the principal tools. Except in relatively mild cases, the solution of the problem cannot be left to the client himself on a *laissez-faire* basis, since he has usually already demonstrated inability to cope with life alone. As in medicine and all other clinical specialties requiring long training and experience to deal competently with all factors involved, it follows that psychotherapy demands the most complete training and experience that are available at a given time and place. In difficult cases the ultimate responsibility of the therapist is to direct the learning process that is inherent in all psychotherapy.

Objectives of the Therapist

If it is accepted that some sort of learning process underlies all psychotherapy, it follows that among the objectives of the therapist are the following: *to make a diagnosis* concerning the nature of the problem in all its ramifications and then *to devise and institute suitable training procedures* for the correction of pathogenic factors. Here, as in almost all clinical practice, the primary and most difficult objective is to discover the nature of the problem, after which suitable remedies usually become apparent. Diagnosis is therefore the foundation of all scientific clinical practice. In our opinion,

current diagnostic methods and categories are woefully inadequate, and in the future the task with the highest priority will be to re-evaluate the whole problem of diagnosis and diagnostic categories.

Premises of Directive Psychotherapy

At this point we may restate a number of premises that underlie directive therapy of all types:

1. The therapist is essentially a *master educator* who takes over where society, family, education, and the person himself have failed to condition healthy behavior.

2. The first stage of therapy consists in establishing suitable conditions for learning a new style of life. This includes establishing rapport, analyzing past conditions of a traumatic nature, releasing emotional repressions and blocks, and giving the client maximum opportunity to solve as much as he can by himself.

3. The concept of directiveness implies that someone must discover what is the matter and what must be done, and then must see that it is done. This procedure involves diagnosis that cannot usually be accomplished by the client alone, and it also involves the great issue of what is to be done therapeutically.

4. The issue is sharpened when facing the concrete decision of *when, where, how, and why* to interfere in another person's life. What is the authority for determining how another person shall be influenced therapeutically? In the past, such vested interests as religions, educational institutions, political parties, and other pressure groups have regarded themselves as suitable authority. None of them is completely valid and satisfactory.

5. It is postulated that the scientific approach provides the most satisfactory authority for undertaking directive therapy. As here used, the scientific method is regarded as the ultimate method of establishing validity and must be given precedence. According to standards of time and place, the broad scientific training provides the highest standards of competence. Science is the common ground on which conflicting authorities must come to agree.

Basic Methods and Patterns

The following outline presents the basic method and pattern of directive psychotherapy in which, though client-centered, the therapist assumes responsibility for conducting all details of case handling according to the highest ethical and professional standards:

1. *Adequate diagnostic studies*, which involves complete case history, clinical examinations, psychometric and projective studies, and laboratory procedures, such as electroencephalography.
2. *Preparation of a descriptive formulation* of the psychodynamics of each case, including etiology, clinical status, personality resources, and prognosis.
3. *Outline of an individual plan of therapy* with client-centered orientation that is specifically related to the needs of the individual case.
4. *Genuine eclecticism* in therapeutically utilizing all the technical resources, either directive or nondirective, which are available at time and place.
5. *Utilization of the principles of experimental science* wherever applicable at all levels of case handling, and especially in etiological studies and psychodiagnosis.

This outline of directive psychotherapy is consistent with the historical evolution of clinical science in general and medical psychology in particular, and it combines the best characteristics of experimentalism and modern clinical science.

THERAPEUTIC IMPLICATIONS OF THE CASE HISTORY

The relation between adequate case-history taking and rational psychotherapy is of both theoretical and practical significance. In modern medical science there is almost unanimous agreement that obtaining an accurate case history ranks in importance with careful physical and laboratory examinations in reaching the correct diag-

nosis which is essential for rational treatment. No exact understanding of either physical or mental dysfunction is possible without a detailed investigation into the etiology and development history of the pathological process. Karnosh and Zucker (8) have aptly stated the general principle as follows:

The understanding of human behavior is a complicated subject for it must include an inquiry into every remote phase of the individual's life history, some of it involving very intimate and personal matters. This longitudinal study of the patient's personality through space and time, together with a knowledge of the immediate mental and physical state, constitutes the psychobiological method of recognizing the nature of mental disorder.

Sadler (13) states:

From every standpoint the physical examination, clinical and laboratory tests, emotional analysis, and personality study—from the time the history is started until the patient or his family are given a diagnosis and the therapeutic procedures are outlined—should be thoroughgoing and exhaustive, embracing every item entering into a conscientious and scientific investigation. I make it a rule not to undertake to formulate a diagnosis or to plan the therapeutic management of a case if the adult neurotic patient is not willing to submit to this careful preliminary study.

Such opinions are typical of modern psychiatric practice which places major emphasis on the taking of objective and detailed case histories.

One of the objectives here is to provide an introduction to the theory and use of the case history as a method of clinical examination and its relation to rational psychotherapy. In the search for briefer methods of psychodiagnosis and psychotherapy there has been some tendency to minimize the importance of an adequate case history. Although the accurate and detailed case history is still the most valid and reliable device at our disposal for evaluating the longitudinal development of the individual, psychologists have largely failed to study and utilize the methods in clinical practice and instead have spent much time and research in developing less effective

substitutes, such as personality inventories, attitude questionnaires, rating scales, and the like.

It is our opinion that every clinical psychologist should be trained in, and become adept in, the taking and evaluation of the case history irrespective of the type of practice that he expects to engage in. Rogers's opinion (12) that the obtaining of a case history is nonessential or contraindicated in nondirective counseling and psychotherapy appears extreme, and considerable harm would result if it were accepted universally. There is need for extensive objective research in elucidating the use of the case history in both directive and nondirective clinical methods.

Need for Accurate Diagnosis

It seems elementary that rational treatment cannot be planned and executed until an accurate diagnosis has been made. Among the diagnostic errors that can be made in the absence of a reliable case history are (a) reaction to superficial appearances, (b) superimposing of preconceived theories that have no valid application, (c) reasoning from false premises and inadequate evidence, and (d) faulty corroboration of facts. The validity of the clinical method depends upon the gathering of all possible relevant facts without which no reliable evaluation can be made. Instead of trying to find the facts to fit some preconceived theory, it is necessary to find a theory that will fit the facts.

In psychological diagnosis it is necessary to elaborate the exact sequence of cause-effect relationships in order to determine whether the behavior disorders have occurred as a reaction to environmental stimulation or are secondary to pathological lesions. Since different etiological factors may produce an identical result and since a given etiological factor may elicit different personality reactions in different individuals, it is essential to obtain enough case history to elucidate the developmental sequences involved in each case.

Occasionally, it is possible to make a "snap" diagnosis by means of recognition of pathognomonic signs or clinical intuition, but the

experienced clinician knows that such diagnoses are more often erroneous than accurate. Conversely, the better the diagnostician, the longer and more detailed will be the case history that he takes. When phenomena are as complex as are the factors that result in maladjustment and mental disorder, it should be obvious that there can be no short cuts to clinical understanding.

Many psychological disorders can be alleviated by suggestion, environmental manipulations, changes of jobs, vacations, and other expedients in the absence of genuine insight into pathological mechanisms or exact diagnosis. Unfortunately, however, the more serious maladjustments do not respond to superficial symptomatic treatments, and no rational plan of treatment can be accomplished without a detailed knowledge of each individual case history.

Determination of the Truth

Serious psychological maladjustments are typically associated with poor interpersonal relationships which eventually result in the subject's being referred to some agency for study. One must always suspect a psychological disorder when a person is brought for study by a friend or relative, the implication being that his associates believe that there is enough wrong to warrant study. In any situation where serious complaints are made by one person against another, the demands of justice and objective research require a thorough investigation of the total situation to determine the truth. This basic essential of clinical investigation is too frequently overlooked by the beginner, who tends to be unduly influenced by the first version of the situation that he hears. *It is very important not to formulate any opinion in a case until all the facts have been impartially evaluated.*

It is commonplace to discover that two apparently irreconcilable stories are both rational and logical when they are evaluated apart from the differing systems of values that the two individuals may hold. Where conflicting systems of values are involved, one can appreciate the merits of both sides of the argument and be unable to

reach any fair decision. Such situations are especially common in marriage counseling, in which both parties may be admirable personalities as individuals but are completely incompatible together. It therefore becomes a necessity to check all significant facts from as many impartial sources as possible. Since it is imperative to check every statement made by a mental case, the case history cannot be taken too carefully and in too great detail.

Detection of Misinformation and Illogical Thinking

It is of the utmost importance to discover the illogical premises upon which unhealthy thinking is based. Sometimes the source of the difficulties becomes obvious after a short interview, but more commonly persistent and careful questioning is required to obtain the complete history necessary for a precise understanding of the situation. Since the patient himself is usually unable to correct irrational thinking or to discover sources of error, it becomes important to develop some systematic method of sampling each area of maladjustment so that a comprehensive cross section of the personality is explored. Personality inventories and questionnaires have some value in rapidly sampling a wide area of responses, but they are decidedly inferior to the skilled examiner who, through experienced judgment in knowing which leads to follow up, is able to elicit the vital information painlessly.

Differentiation between Functional and Organic Complaints

The clinical psychologist should be constantly alert to the danger of treating organic complaints that require medical attention. In the same manner that the medical physician's training in organic pathology frequently predisposes him to minimize psychogenic factors, the purely psychological training of a psychologist makes him insensitive to the possibility of organic pathology. It is invaluable for the clinical psychologist to learn the rudiments of organic pathology and symptomatology and to participate in clinicopathological con-

ferences with physicians and psychiatrists in order to gain enough knowledge to be able to recognize the grosser evidences of organic disease. At the same time he should demonstrate good judgment in not allowing this limited knowledge to lead him into fields in which by training he is incompetent to work.

The case history is extremely important in determining the organic or functional nature of the complaints. Symptoms present for years without material change in the condition of the patient suggest functional disorders, whereas sudden or abrupt personality changes may suggest a rapidly developing organic lesion. The history of the onset of a disorder in relation to psychic stresses or emotional disturbance suggests functional or psychosomatic disorder. The histories related by neurotic patients are frequently vague, ill defined, bizarre, inconsistent, and unclear, whereas organic syndromes are usually clear cut, well defined, and consistent and conform to known patterns. The neurotic makes exaggerated complaints about minor symptoms; he overreacts to pain, is excessively sensitive to inconsequential stimuli, and presents peculiarities and idiosyncrasies that differ from known patterns. Alvarez (1) points out that organic symptoms are frequently inconstant and appear in relation to definite stimuli, but many neurotics complain of constant severe symptoms which are associated with much anguish. There can be no substitute for either the information or the direct observation of the client that are obtained while the history is being taken. Valuable insights concerning the total personality would be lost if this part of the examination were eliminated or inexpertly performed.

Establishment of Rapport

The manner of eliciting the case history is directly related to the ease and efficiency with which rapport is established. The first minutes of a clinical meeting may be strained and embarrassing for the client as he begins to relate the most intimate details of his life to a complete stranger. The efficient elicitation of the case history not only provides a natural method of professional commu-

nication with the client but also tends to make him less self-conscious and uncomfortable as his attention is distracted to the problem of answering questions intelligently. If the history is elicited painlessly, it is possible to build up in a few interviews a degree of rapport that would take much longer in any other social situation. The client naturally develops a rapport very quickly with a person who knows so many of the intimate details of his life.

Too much emphasis cannot be laid upon the fact that the client gets his first impression of the clinician from the initial interviews while the history is being obtained. The client will usually react unfavorably to anything unnatural or disturbing that occurs during this introductory period. The psychologist would do well to assume a passive, nondirective attitude during the initial contacts, interjecting only enough to elicit a coherent history.

Desensitization

Under our present inadequate system for referring problem cases, many clients do not reach the psychiatrist or psychologist until all other resources have failed. It is unfortunate that most people believe that conditions must indeed be serious if one has to request psychological treatment. For these reasons it is important to give every client the opportunity to uncover the fears and anxieties that led to the clinical contact. It is necessary to discover (a) why this patient is anxious or terrified; (b) how his fear originated; and (c) what can be done to relieve or reassure him. These questions are all usually answered if the history is obtained in enough detail, and the client may begin to feel relief if the questioning is carried out in a manner satisfying to him. The client begins to establish immunity against psychic pain and emotionalism as he is led to discuss his problems objectively for the first time. Many patients have made a great effort to keep their weaknesses and sufferings secret in the mistaken belief that to reveal them would be cowardly or depreciating to their self-esteem.

The first step in achieving desensitization is to ventilate the

whole complex in such manner that values are seen in true perspective. The client finds that the counselor is neither censorious nor moralistic. What previously had seemed to be an insupportable burden now becomes merely one of the trials that every human being experiences sooner or later. The client learns that others have had similar troubles and that effective solutions are possible. What had previously been a closely guarded secret or concealed weakness is now evaluated to see whether it can be made into an asset rather than a liability.

The patient should be reassured that many behavior problems are *alarming but not dangerous, annoying but not detrimental to mental health*. Many people magnify their problems to such gigantic proportions because of misinformation or superstition that great relief is obtained by presenting simple factual explanations which can be easily verified by the client if he does not wish to trust the psychologist completely. It may be of great value to the client to discuss the cases of other persons who have had similar difficulties, with the objective of illustrating that such problems are not life-and-death matters and that good solutions are known.

CASE OF T. F. Male, age 25, single. Referred for consultation by urologist because of dull bladder pain occurring as bladder becomes distended and relieved by urination. Complaint gradually grew worse for last 7 years. Says that it has worked on his nerves until he can't stand it much longer. Unrelieved by medications, urethral dilations, prostatic resection, and bladder washings.

Says that bladder trouble first started at age 5 in first grade. He had a very disagreeable teacher who terrified him by her cruelty from the first day. He was afraid to ask to be excused and held his water for hours until recess. Got along fairly well until age 17 when worked under a strict boss who "Bawled me out all the time." Rejected for military service in 1941 because he got "all nerved up and couldn't make water" at the induction station. Obtained mill job but had to leave his bench frequently to urinate because of bladder discomfort. Couldn't urinate in front of others. Felt uncomfortable in mill job and wants to get quiet job working alone.

Reacted quickly and favorably to explanations of the psychosomatic

nature of the disorder, reassurance that symptoms were all functional and annoying but not dangerous, and that his bladder complaints and inability to urinate in public were related to emotional instability conditioned by childhood experiences.

While the above case history was being taken, it became apparent that T. F. was gaining considerable relief from the desensitizing experience of relating events that had been both embarrassing and shameful to him. The relief came because the counselor was able to reassure him with convincing explanations that his troubles were understood, not seriously dangerous to health, and susceptible to known methods of treatment.

Catharsis and Abreaction

For whatever therapeutic values may be involved, the taking of a detailed case history provides the client with an opportunity for catharsis and abreaction. It is never possible to determine which cue is going to open the floodgates to an uninhibited flow of material which the client needs to bring into the open. Many persons find it difficult and unnatural to air their complete story to a stranger during the first moments of clinical contact, but their confidence and trust grow as they find it possible to relate their troubles in a friendly, noncritical environment. One of the values of the psychoanalytic technique is that it provides a leisurely method for intensively exploring the depths of personality under conditions conducive to the uncovering of all pertinent material. There can be no effective short cut for the detailed and continuing case history, and without it no deep understanding of the personality is possible.

The phenomenon of abreaction can be objectively studied in many psychoneurotic patients who frequently present a convincing array of psychosomatic symptoms while discussing disturbing experiences during the taking of the case history. It is fairly common for the client to become suddenly tense, to begin to breathe in sighing respirations, to assume an anxious expression with beads of sweat on the forehead or upper lip, to perspire profusely, and to develop other

signs as he discusses the experiences that lie at the root of his trouble. This situation can occasionally be turned to therapeutic advantage by calmly pointing out to the client the relationship between disturbing thoughts and psychosomatic disorders and getting him to admit the causal relationships involved. It can also be pointed out that the conditioned reaction is no longer appropriate, since the stimulus which originally elicited the reaction is no longer present, and that the tendency to mull over unpleasant thoughts prevents mental healing in the same way that picking at a scab prevents the wound from healing.

Reassurance

People ask for psychological help because they have problems that are too difficult to solve alone. It is reassuring to be able to share one's burden with others. Once having requested assistance, most people desire the most complete diagnostic examination that can be made and are dissatisfied with cursory investigations which patently do not reach much beneath the surface. Completeness in obtaining the case history is reassuring to the patient, who is impressed to know of the carefulness of the clinician and is flattered by his interest. As Andrews (2) has emphasized, anything which tends to reassure a patient has therapeutic value in building up rapport and winning mutual confidence and respect. The clinician must not forget that for the patient the solution of his problem is paramount, and nothing that might have bearing on the case should be neglected. Most patients expect that a detailed history will be taken and are quite naturally suspicious if this is not carefully done. Thus, reassurance is a therapeutic technique that may be used throughout the therapist-patient relationship, both during the taking of the case history and in later interviews when more specific problems are discussed.

In terms of psychotherapy, reassurance means the strengthening of positive attitudes and the restoration of self-confidence by selectively reinforcing healthy behavior with rewards or incentives in the

form of assurances. Reassurance is a natural psychological antidote for the negative emotions of fear, worry, doubt, and uncertainty. Through reassurance a person re-establishes confidence by being made aware of certain facts that operate to remove fear and feelings of insecurity. The art of reassurance has been so extensively practiced by physicians, clergymen, teachers, friends, and relatives that it hardly deserves designation as a special technique in guidance unless it is so skillfully utilized that it goes beyond ordinary common sense.

Reassurance is a form of symptomatic therapy in which certain superficial needs of the client are satisfied in order to deal with some of the factors which are most disturbing at the moment. It operates as an antidote for some of the negative feelings and ideas associated with maladaptive behavior. Some elementary types of reassurance which may help many clients are given here:

1. REASSURANCE THAT CASE IS NOT UNUSUAL. Many clients have had no experience with personality disorders and are bewildered and fearful. They fear that they are unique, rare cases unlike anything ever seen before. The counselor may reassure the client that the disorder is very common and not unusual.

2. REASSURANCE THAT NATURE OF CONDITION IS KNOWN. All persons are fearful of the unknown, perhaps more so than of the known. It is reassuring to know that the disorder has a known cause and that, therefore, presumably something can be done about it.

3. REASSURANCE THAT SYMPTOMS ARE ANNOYING BUT NOT DANGEROUS. Anxious persons tend to fear the worst. Their imaginations about disease are frequently worse than the real thing. Explanations of the nature and prognosis of symptoms may be very reassuring.

4. REASSURANCE THAT SOMETHING CAN BE DONE. It is not enough to know that the nature of the disorder is known. The client is also interested in whether anything can be done. Traditionally, mental disorder has been very alarming and productive of anxiety because of the implications of such statements as "he lost his mind," which imply that what is gone cannot be recovered. The client needs to know that specific methods of treatment are available.

5. REASSURANCE THAT CURE IS POSSIBLE. The client's principal interest is to get well. He can usually tolerate symptoms if he knows they are temporary.

6. REASSURANCE THAT CLIENT IS NOT GOING CRAZY. Most clients have conscious or subconscious fears that their condition may lead to insanity. A client may not admit such anxieties, but they are usually there. He wants to be told that this will not happen.

7. REASSURANCE THAT RELAPSES MAY OCCUR. Any temporary relapse or setback may be interpreted as a sign that the condition is getting worse. The client should be warned of the inevitability of relapses and reassured when they occur.

8. REASSURANCE THAT CLIENT IS NOT SINFUL OR BLAMEFUL. The popular identification of mental disorder as a result of sinful actions stimulates guilt reactions and attempts to fix blame or gain revenge. Reassurance that this is not a moral problem but can be understood only with impersonal, objective, scientific attitudes may relieve some clients.

If it is borne in mind that too free use of reassurance may tend to "block" emotional release by giving a premature and superficial relief from presenting symptoms, all of these types of reassurance may be freely used if they state the *true* condition of the specific case. Some therapists tend to reassure the client along the lines indicated as a matter of course, for the purpose of dealing immediately with the standard types of fears that clients are known to have and also dealing with un verbalized anxieties which the client may not even be aware of. Occasionally a client with close-to-the-surface anxiety feelings may overreact when the counselor spontaneously gives these reassurances and may jump to the conclusion that there must be something to worry about if the counselor brings up such matters. This reaction is revealing but not dangerous if the counselor proceeds to give further reassurance that the mention of these matters was not intended to refer specifically to the client since they are given routinely in every case.

Probably the safer technique is first to recognize, accept, and clarify the client's demands for reassurance nondirectively, thus per-

mitting the client to express himself concerning his fears. After the expression seems complete, reassurance may be given appropriately as a form of positive conditioning intended to reinforce the new pattern of behavior and insights that are developing through therapy.

Reassurance may be communicated from one person to another in many ways other than words. *Reassurance is most effective when it is given on both verbal and behavioral levels*, that is, when actions support and reinforce the effect of words. Too frequently reassurance fails because the client discovers that verbal formulations are erroneous and quickly learns to disregard words that are unsupported by actions. Reassurance is most consistently effective if the total environment is manipulated in such a manner as to restore self-confidence and give feelings of security. It is usually most effective to support verbal reassurance on the intellectual level with behavioral reassurance on emotional levels in order to reach both rational and emotional levels of personality. For example, a rejecting parent may give an unhappy child repeated verbal assurances of love, but the assurances are not convincing because the parent fails to reinforce the words with kisses and caresses that the child emotionally craves.

A basic consideration in giving effective reassurance is the degree of positive rapport between counselor and client. The client should have sufficient confidence in the counselor to accept unhesitatingly whatever reassurances are given. Any conditions or circumstances that enhance rapport will operate to reinforce the effect of reassuring words or actions. The client-counselor relationship has begun to be successful when the client gains enough confidence in the counselor to begin to accept and act upon reassurances.

Many clients have a need to be reassured in connection with specific fears and anxieties. Many clients express such need for reassurance as early as the first interview, to which they have come fearing the worst, and at the end of which they usually question the counselor concerning the diagnosis and prognosis. Most clients want to know what the results of the first interview are and are usually ready with questions concerning their anxieties and fears if the coun-

selor gives an opportunity to express them. To tell anxious clients nothing, as in passive methods, such as nondirectionism, may subtly increase the client's anxiety if he gets the idea that the condition must indeed be bad if it is necessary to hide things from him. In cases in which the diagnosis or prognosis is unfavorable, it is usually advisable not to reveal such facts to the client. If the diagnosis or prognosis is favorable in whole or in part, the client may be reassured by being given positive information to allay the worst of his fears.

One technique is to recognize, accept, and clarify the client's anxieties first and then give such reassurances as may be indicated as in the following case.

CASE OF MRS. G. Age 29, college graduate, two children, housewife, was referred for complaints of severe anxiety, inability to go out on the street alone, fears of insanity, tachycardia and "butterflies in my stomach." She expressed typical feelings of anxiety during the first interview which ended as follows:

CL.: Now that you have heard all of this, what do you think of me? Do you think I'm pretty bad?

Co.: You have felt afraid because you didn't know what was going to happen.

CL.: I didn't know what was the matter with me. All I know is that I feel terrible.

Co.: All sorts of terrible thoughts and fears have been bothering you.

CL.: Well, after all, I am pretty young to have anything like this. I didn't know what to think.

Co.: Probably you even had ideas that you might be going crazy, or losing your mind or something else like that.

CL.: Now that you mention it, that does bother me. It frightens me. Something must be the matter if I feel this way. Tell me, what do you think?

Co.: I'm going to tell you the truth so you needn't have too many doubts about it. I am sure that you are never going to go crazy or lose your mind or anything like that. You do have a kind of garden variety of nervous breakdown if you want to call it that. It is not too dangerous, and there is nothing too serious to worry about but still it is something

that needs to be taken care of. Fortunately, we know about these things and we know how to cure them. It may take time, but eventually you will be as good as ever. Is there anything else you want to know?

CL.: If only I could believe that. It seems too good to be true. I have been so worried that I put off coming to you for a long time. I was afraid you were going to tell me something terrible. I guess I feel much better even now. At least that worry is off my mind.

The more factual and convincing the reassurance, the more effective it is in counteracting anxiety. It is interesting to compare the effects of reassurance as given with varying degrees of factual support. In the following excerpt, the reassurance will probably be ineffective because it is too vague and is supported only by the prestige of the counselor:

CL.: I haven't been feeling very good this week. Yesterday I cried a lot because I kinda felt it was hopeless.

Co.: Oh, don't worry about these little setbacks. You are going to be all right. Just sit tight and don't let yourself get discouraged. I think you are much better.

This counselor response obviously represents a crude and ineffectual type of reassurance that actually has such deleterious effects as the blocking of the client's emotional expression and the prevention of an adequate handling of the disturbing material. Unless the client is very suggestible or has problems that are very minor, such handling will not be very effective.

Sharing the Burden of Trouble

There is a large group of moderately maladjusted people who can carry their burdens of trouble, provided that they can receive help and emotional support at critical moments when the weight of overwhelming circumstance seems to become temporarily intolerable. These people exist in a precarious state of psychological balance in which they are able to adjust when things are going favorably but become discouraged and emotionally disturbed when circumstances grow more difficult. They may be compared to freight locomotives

that can pull heavily loaded trains on the straightaway but need helper engines in surmounting occasional grades.

Over a period of years, the practicing clinician gradually accumulates a group of these cases who seem to be benefited by coming and relating their case history to a professional person in whom they have confidence. Frequently the clinician has to do nothing more than sit and listen or give expressions of sympathy and offer to be available in case of emergency. Although it is the objective of treatment to make the patient as independent and psychologically self-sufficient as possible, even the most integrated person has moments of insecurity during which the mere presence of a trusted support and adviser is reassuring. In such cases the patient is benefited by sharing his problems and knowing that assistance is available if needed.

Many patients derive emotional security from the knowledge that someone knows their case histories. It is not unusual for a patient to insist upon relating the past history in much more detail than the clinician thinks is necessary. If the client shows a need to unburden himself, it is necessary to permit such outlet. Failure of the clinician to investigate the total situation comprehensively enough to satisfy the client or to listen patiently to matters that seem important to the client is frequently given as a reason for changing professional consultants. In such cases the clinician is accomplishing something simply by carrying the client over the difficulties of the moment, confident that mental balance will be achieved in the future when the environmental situation becomes more favorable.

Inducing Insight

It is hardly possible for the patient to avoid perceiving causal relationships and gaining insights into his maladjustment as the clinician systematically elicits a detailed history concerning the total life situation that resulted in behavior problems. As pointed out by Alvarez (1), the eliciting of a good history will frequently

cure some of the milder psychoneurotic disorders in cases in which the patient had never before perceived all the facts in proper relation to each other. Not only will a carefully taken case history stimulate the person to think about himself along new lines, but frequently a challenging question, inserted subtly, will force the person to reorient himself to certain problems.

Many factors related to history taking appear to determine the beneficial results that are frequently observed. First, the patient derives some benefit from noting the quiet way in which the skilled questioner receives even the most dramatic revelations. The client is led to understand that the circumstances that upset him so much may not be calamitous after all. Second, the counselor is given opportunity to insert many little explanations. Possibly no single one of them will seem important, but all of them will reinforce one another in producing systematic insights. Third, the client is led to explore many causal relationships and to review the circumstances that led to his present condition in a quiet, objective manner that also produces insight.

The following excerpts from a marriage-counseling interview illustrate the manner in which clients think over the course of questioning and try to reason out the rationale of the whole procedure.

CASE OF MR. P. Mr. P. came for counseling concerning what he should do about his second wife, from whom he was rapidly becoming estranged. In the first interview he related a long story concerning his wife's peculiar actions, which he thought constituted evidence that he was becoming mentally deranged. He admitted no responsibility for any of the unpleasant altercations which had occurred and attempted to explain them all on the basis of his wife's instability.

MR. P.: You know, I've been thinking about something you said the other night. You asked me how it happened that this is the second time that I'm getting divorced.

Co.: Did you reach any conclusions?

MR. P.: Well, maybe I'm just not very good at picking 'em.

Co.: I wouldn't say that. I thought your wife was very nice, what little I saw of her.

MR. P.: I know that. She's all right in her own way. It is just that I can't get along with her I got to thinking that maybe I've been a little rough with them.

Co.: What do you mean?

MR. P.: I didn't tell you this before, but one night I got home from work and there was no dinner ready. I said, "What've you been doing?" She started jawing back at me and then we were at it. I got so mad I turned her up and let her have it with a belt. I guess I shouldn't have done it, but you should have seen how mad she made me. She wouldn't leave me alone.

Co.: How do you feel about it now?

MR. P.: I guess any man would have done the same thing. . . . I don't know though. Maybe a man shouldn't do that, no matter what happens.

In the short sequence transcribed above, Mr. P. has arrived at a partial insight in that for the first time his attention has been directed to the matter of his own responsibility for his marital difficulties. In the fourth interview he finally reached the point where he could admit that he was at least half to blame for their difficulties. This result was achieved by patient questioning intended to bring out the exact events that led up to each of his difficulties with Mrs. P.

Prediction of Behavior

The experience of neuropsychiatric examiners engaged in Selective Service and Army Induction Board work points to the conclusion that an adequate case history is the most reliable source of information upon which to base predictions of future behavior. It seems almost axiomatic that an individual personality can be best understood in terms of detailed knowledge concerning longitudinal development and existing patterns of behavior. The importance of the case history is so unequivocally admitted in modern psychiatry that it is referred to as the *indirect examination* of the patient as compared with *direct examination*. The objective of the latter, of course, is to evaluate the mental status of the patient at a given

moment. The case history or indirect examination provides the background information from which an evaluation or interpretation of dynamic factors can be obtained.

The mental status of a person at any given moment is a resultant of the interaction of a large number of variables, many of which are discoverable through utilization of the clinical methods that are available to the examiner. To attempt to understand or predict behavior without the most complete information concerning the variable factors that determine the behavior pattern is comparable to attempting a chemical analysis without making tests for individual elements. Interpretations and predictions of behavior cannot be expected to have any high degree of reliability unless they are based on a thorough knowledge of past history as obtained from an adequate case history.

The Technique of History Taking

Since the objective of the case history is to make a longitudinal study of the individual's psychobiological development, it is desirable to obtain information concerning development and adjustment in each area of human activity. It will be convenient to elicit information more or less systematically and according to a definite outline. Manuals of mental-examination methods, which include suggested outlines for questioning, have been written by Franz (6), Kirby (9), Cheney (4), and Preu (10). An abbreviated outline of significant data in the most important areas of life that it is usually desirable to sample is presented below. This outline should be expanded according to the needs of each individual case with an effort being made to investigate all possible details of development which may conceivably be related to present problems.

SUGGESTED OUTLINE OF CASE HISTORY

I. IDENTIFYING DATA: Name, address, date and place of birth, race, marital status, educational status, religion, source of reference, data concerning informants. Mental age or IQ if known.

II. **PRESENT PROBLEMS:** Give an exact account of all present difficulties in chronological order of their occurrence. Mention dates, special instances, and directed quotations from patient or informants when possible. Do not list delinquency or other specific charges unless verifying information is included (or available).

III. **FAMILY HISTORY:** Include all significant data concerning father, mother, siblings, and other relatives. Mention names, birth dates and places, occupations, education, health, temperament, and personal peculiarities. Indicate especially habits, such as alcoholism, criminal or anti-social tendencies, nervous or mental disorders, convulsive disorders, and diseases, such as syphilis.

IV. **PAST HISTORY:**

1. **Circumstances of Birth:** Pregnancy of mother, conditions of delivery, operative interference, complications of birth.
2. **Developmental History:** Age of sitting, standing, walking, talking, bladder and bowel control and any other significant data.
3. **Medical History:** Nature and dates of childhood diseases, injuries, accidents and operations. Statements of growth characteristics, nutrition and general health. Attitudes toward own health.
4. **Educational History:** School progress, highest grade attained and at what age, aptitudes and disabilities, marks, attitudes toward teachers and schoolmates, disciplinary problems, educational goals.
5. **Emotional Developments:** General characteristics of emotional life, predominant moods, stability and excitability, special problems such as temper tantrums or phobias, emotional conditionings and attitudes toward others.
6. **Sex Life:** Age when first manifested, pattern of development, autoeroticism, homosexual tendencies, heterosexual adjustments, love affairs, marital adjustment, special problems.
7. **Social Development:** Degree of sociability and adaptability. Play life, recreation and diversions. Self-confidence, dominance and submission. Patterns of social life, social acceptance by others. Asocial tendencies, criminal record, continued maladjustment.

8. **Work History:** Nature and dates of employment steadiness and quality of work, attitudes toward work, frequency of job changes and reasons, future plans.
9. **Family Life:** Attitudes and conduct toward parents, siblings, relatives, wife, children. Response to authority, criticism, little irritations. Previous engagements, separations, divorces, and reasons. Statement of general compatibility of areas of disagreement.
10. **Personal Habits:** Eating, sleeping, play, work, sex, alcohol, drugs, tobacco. Behavior problems such as lying, stealing, truancy, stuttering, stammering, enuresis, tics, mannerisms.
11. **Attitudes toward Self:** Inferiority feelings, dominant traits, neurotic disability, personality development, goals. Mental health.
12. **Socioeconomic Status:** Economic level, unemployment, contacts with social agencies, living quarters, social level, reputation in neighborhood.

Suggestions for Obtaining a Good History

1. There are no short cuts to obtaining a complete history. Do not hurry. Allot enough time in the all-important first interview to obtain an adequate orientation to the client's problems.
2. Let the patient tell his story in his own way, with a minimum of suggestion or direction.
3. After the basic outlines of the problem are visualized or if the client has difficulty in telling a coherent story, elicit further details according to some such outline as is given above. The use of an outline minimizes the chances of overlooking significant data.
4. Questions should be asked as nondirectively as possible. By simply asking How? When? Where? Why? the significant details can be elicited without suggesting specific answers.
5. Sex problems are best discussed during the first interview unless there are contraindications. Frank, common-sense questions usually elicit the same type of answers.
6. Make certain of the meaning of all critical words used by the client; laymen frequently confuse or misunderstand professional connotations.

7. Transcribe significant or representative samples of the client's statements verbatim. The facts in the case history should be transcribed as exactly as possible so that a third person may evaluate them as objective facts. Interpretations made by the psychologist should be clearly indicated as such.

8. It is frequently valuable to question in great detail the client's daily habits in life. What does he do in a typical day?

9. Significant details should be elaborated and checked by systematic cross-questioning in order to obtain as complete information as possible.

10. Ask the client what he thinks and how he feels about significant things that have occurred. It is necessary to discover not only what happened but how the client reacted to it.

11. It is unwise to hazard a diagnosis without first inquiring what conclusions the client has reached by himself and also what other consultants have said.

12. It may take months to obtain all the significant details of the case history. Each successive interview should be the basis for eliciting further details concerning the past history.

13. When resistance is encountered, indirect methods may prove more effective than insistent directive questionings. It is frequently effective for the clinician to cite experience derived from other cases in which the client may become so interested as to more freely relate the details of his own experience.

THERAPEUTIC USE OF CONFLICT

Although conflicts can probably never be eliminated completely, nevertheless, one of the conventional objectives of psychotherapy is to remove conflicts. From this it logically follows that a mentally healthy personality is one with a minimum of conflict.

Conflict may be regarded as a normal and inevitable concomitant of the complexity of stresses that every personality encounters. The normal child quickly learns to adapt himself to conflicting tensions and frustrations. Not only is conflict inevitable, but it oper-

ates as a powerful corrective influence tending to force the individual to orient himself to the demands of reality. Thus, punishment may be administered in a deliberate effort to arouse a conflict in a child's mind as to whether misbehavior pays. As an individual becomes more and more maladjusted, natural corrective forces in the environment begin to operate in such manner that the social consequences of his conduct are more and more firmly impressed upon the person. A normal personality develops a conflict over the impasse between his impulses and the reality principle which usually terminates in a reorientation of his attitudes in the direction of socialization of behavior. In such situations it is necessary to precipitate a conflict in the person's mind before he becomes motivated even to face, much less solve, his problems.

Technique of Application

In selected clinical situations, a therapeutic conflict may be created by more or less forcibly confronting the client with factual information or explanations that stimulate him to re-evaluate certain attitudes in the direction of making them consistent with reality. Ideally, these new facts should be presented so cogently that they cannot be ignored but must be assimilated, resulting in a reorganization of all the client's attitudes in specific areas. The client is brought face-to-face with the reality principle under circumstances in which there is the optimum chance to work out a satisfactory solution under the care of a psychiatrist or psychologist.

Much depends upon the clinical skills with which the total situation is handled. Most individuals are able to assimilate unpleasant facts if the situation is arranged so that positive factors outweigh negative and if the client is not placed on the defensive by tactless handling which stimulates negative attitudes. Most clients will "take" a critical review of their problems if it is presented in an impartial, nonjudgmental manner which minimizes interpersonal emotionality. We do not agree with many nondirective counselors who believe that such methods inevitably stimulate negativistic de-

fensive reactions and interfere with the progress of therapy. On the contrary, the occurrence of some negativism is regarded as a natural part of the therapeutic process and is undesirable only when it is so poorly handled by the clinician that it becomes uncontrolled and disrupts the therapeutic process.

In a typical treatment process, it is expected that the client will show resistance when the crux of his problems is about to be uncovered and dealt with. His initial reaction to the presentation of conflict-arousing facts will be to reject them verbally and to develop negativistic attitudes toward the counselor. The counselor in turn simply allows the matter to lie dormant for a period of days or weeks until the client shows evidence of having assimilated the new facts and begun unconsciously to reorganize his attitudes in the direction of eliminating inconsistent attitudes and of achieving a resynthesis that is more compatible with reality in the new light in which it comes to be seen. When the client has achieved this unification of his attitudes, he usually has insight into the value of the work done by the counselor and begins to show positive attitudes again. During this period of resynthesis of attitudes toward life, it is the function of the counselor to guide the process in the direction of increased internal consistency and agreement with reality. There seems to be a positive correlation between the intensity of the induced conflict, provided that the conflict does not completely paralyze mental economy, and the degree of motivation to solve his problems that the client shows.

Clinical experience will determine the details of handling each individual case. Well-integrated personalities who have abundant resources will frequently work out their own solutions satisfactorily, once they gain orientation concerning the inconsistencies of their attitudes in relation to reality. Immature personalities who have less personality integration may require counseling over a relatively long period of time and the outcome of therapy may be related to the wisdom of the solutions that are worked out jointly by counselor and client. It is desirable that the counselor intervene actively only when the client fails to achieve a solution independently. However,

having induced the conflict, responsibility rests with the counselor to make certain that it is utilized constructively and produces a satisfactory therapeutic result.

Indications of Personality Integration

Basic to this type of directive therapy is the assumption that the client has sufficient personality integration and can handle the induced conflict in a constructive manner. The counselor can usually obtain some estimate of the client's ability to assimilate and utilize the newer attitudes by leading up to the crux of his problems indirectly, introducing critical ideas cautiously to determine what the client's reaction will be. If the client assumes a positive attitude and shows evidence of ability to utilize induced conflicts constructively, it is usually sufficient to keep in touch with the situation nondirectively by allowing the client to work out his own solutions so long as he seems in no danger of worsening his status.

Contraindications

The following factors may be considered as contraindicating any attempt to force the client to come to grips with his problems by inducing conflicts:

1. **INSOLUBLE PROBLEMS.** If the client faces problems for which compensatory behavior seems impossible, it can do no good to aggravate feelings of insecurity and inadequacy with the production of increased anxiety reactions.
2. **INADEQUATE PERSONALITY RESOURCES.** If the client has demonstrated an inability to solve existing problems, it can do no good to superimpose added responsibility.
3. **CONFLICT-RIDDEN PERSONALITIES.** Existing insuperable conflicts will rarely be improved by adding additional problems.
4. **MALIGNANT PERSONALITY DISORDERS.** In cases in which personality resources have been depreciated by severe neurotic or psychotic reactions, so that the individual has lost integration and control, induced conflicts will usually exaggerate existing problems.

It is also contraindicated that conflicts should be induced by causing the client to defend himself against unwarranted personality depreciation. This method of inducing conflict is so potentially dangerous in the hands of the novice that its use should probably be restricted to situations in which less drastic methods have failed. It should not be used routinely.

THE TECHNIQUE OF PSYCHOLOGICAL PALLIATION

In medical terminology, a palliative is a remedy or technique which reduces the severity of a pathological condition, affording relief but not cure. Palliatives are prescribed in an effort to reduce the pain or unpleasantness or involvement to a point where the condition becomes bearable and the patient is no longer psychologically incapacitated. The clinician should understand clearly that the palliative is not a specific curative agent but that it has value in diminishing or relieving the intensity of the symptoms. Thus, in any given treatment situation there may be administered a specific remedy with known curative value and palliative remedies intended to afford symptomatic relief but not cure. The general purpose of palliation is to reduce the severity of unpleasant symptoms until such time as nature or some specific remedy effects a cure. Rational therapy therefore depends upon a combination of symptomatic palliation and specific therapy directed against the etiological pathological process.

There are clear indications of the value of palliation in psychotherapy. There are many clinical situations in which it becomes necessary to attempt symptomatic relief before undertaking more specific procedures directed against the underlying psychopathological condition. As long as the clinician has rational insight into the therapeutic nature of the objectives of the techniques that he is using, there would seem to be no basic objection to the expedient use of methods that afford symptomatic relief and thereby facilitate

the operation of specific curative therapy. Much of the dissatisfaction that has resulted from the therapeutic use of such "surface" methods of treatment as reassurance, persuasion, suggestion and other directive techniques may be explained on the basis of a lack of understanding concerning their indications and limitations. When the clinician clearly understands that certain methods operate primarily as palliatives and have little or no specific therapeutic action, he will estimate more carefully the situations in which to apply them.

Major Crises during Adjustment

There are many individuals who are so poorly integrated and so lacking in resources for withstanding environmental stresses that life is a succession of crises. Periodically such a client reaches a climax of frustration in which everything goes wrong and he is "at his wit's end" about what to do next. Then intense emotional reactions supplant the intellectual responses that have been ineffectual in solving the problem, and the client may become so excited and agitated that no rational attack upon the situation is possible. In such situations the client may engage upon a frantic course of trial-and-error behavior or may commit some extreme action which only exaggerates his difficulties.

Palliative measures are usually effective in carrying the patient over his most agitated moments until the climax of difficulty has been passed and he once more becomes capable of efficiently mobilizing his resources for a more rational attack upon his problems. Every clinician is familiar with the anxious patient who telephones at 4 A.M. to obtain help after spending several sleepless hours contemplating problems which no longer seem bearable. There is also the patient who comes to the office in a distraught state with complaints which are so insistent that something must be done immediately. In such situations, reassurance and simple directive therapy are usually effective in alleviating the most urgent symptoms and in tiding the patient over until such time as a more basic approach can be attempted.

Minor Periods of Instability

Almost every person passes through transient periods of maladjustment and instability which can be expected to resolve themselves spontaneously without major psychotherapy. The therapeutic objective is to protect the patient from unwise or impulsive actions and to support his morale until environmental difficulties lessen and better judgment returns. In such situations, it should be clearly recognized that the client's personality is basically healthy and needs only temporary support until such time as balance returns. Many psychotherapists overreact to transient instabilities and institute major treatment projects that are contraindicated and may even be dangerous.

When an undesirable personality pattern appears to represent a *direct reaction* to known environmental stresses that can be expected to resolve themselves in the near future, either spontaneously or through manipulations, there is clear indication of the need for such palliative measures and directive techniques as may assist the client in reaching a rapid solution to his problems. If the client is obviously on the wrong track or completely baffled as to the next step, there should be no hesitation in outlining a plan of action that may not be perfect but has the advantage of at least taking some positive steps. Such patients are usually ready to try anything that offers a chance of success, and we have rarely encountered negative reactions, such as antagonism or resentment, from giving directive advice. If no good plan of action can be outlined or if the patient seems loath to accept advice, we emphatically recommend that the client should do nothing until he is absolutely certain what he wants to do.

Insoluble Problems

There are many clinical situations that seem incapable of any satisfactory solution. After the client has achieved free expression of feeling and obtained insight, he may still be at an impasse because of unalterable reality. Some of the factors contributing to

insoluble problems are irretrievable mistakes, lost opportunities, personal tragedies, constitutional inadequacy, chronic ill health (either physical or mental), and a large number of other conditions over which the individual has little control. Some individuals appear to be "dogged by bad luck" or "born under an unlucky star"; through no fault of their own they experience sequences of hardship and maladjustment about which very little can be done.

It is valuable to provide support through difficult periods of adjustment by the use of palliatives and other methods which protect the patient against impulsive actions and lessen the acute unpleasantness of the total situation.

Distressing Symptoms

It is frequently necessary to palliate distressing symptoms before attention can be directed to basic etiological causes. Recent literature has stressed the importance of treating underlying causes rather than symptoms, and some clinicians have gone to the extreme of ignoring symptoms, on the assumption that the symptoms will automatically disappear if the basic etiological factors are alleviated. In many instances, patients are told that their symptoms are only "nervous" and that they should pay no attention to them. Such methods of handling distressing complaints are bewildering to the patient and may result in loss of rapport.

It is sound psychotherapy to palliate distressing symptoms or pressing complaints before dealing with more fundamental problems. Practical judgment is required to determine when and how it is expedient to deal with symptoms in order that therapy may progress satisfactorily. Often it is sufficient for the clinician merely to "appear" to be doing something about the complaints that disturb the client most. As the treatment progresses, the complaints are frequently completely lost sight of when the client gains perspective and insight into the total pattern of maladjustment.

Supportive Therapy

It may be valuable to utilize palliative methods in carrying the client over the acute period of his disorder until a long-term program can become effective. In cases that involve complex environmental manipulations and require a relatively long period of time for accomplishment, during which the client derives relatively little relief and sees little being accomplished, supportive therapy is definitely indicated. In the treatment of psychoneuroses and other conditions, in which improvement is slow and an intensive program of psychotherapy and rehabilitation must be followed, it is important to facilitate the major objectives by palliating the symptoms and complaints that seem momentarily urgent to the client. Any support that improves rapport and helps the patient through a difficult period of adjustment has value. There would seem to be no objection to the use of this type of palliative measures as long as their limitations and indications are clearly understood.

Symptomatic Treatment

The effective handling of many cases may depend to a large extent upon the degree to which the client is given relief from distressing complaints. At times it may be expedient to compromise between what the clinician thinks is most important to treat and what the client considers his major problems. Although the clinician may be correct in his evaluation of long-term factors in the total situation and may minimize the client's complaints as only symptomatic of underlying psychopathological conditions, such interpretations may seem to the patient to provide little relief for his present difficulties. For example, a patient who has a severe anxiety reaction may be most concerned with the alleviation of his symptoms, whereas the clinician may be most concerned with the removal of the underlying etiological factors. It may be good psychotherapy to treat the patient on both symptomatic and "deep" levels so as to afford temporary relief until major therapy has a chance to become operative.

There has been a discernible tendency in the modern, impersonal, medical-center type of practice to minimize the importance of the patient's feelings in the effort to be completely scientific and objective. Either the patient comes to be viewed coldly as simply another biological organism to be run through the therapeutic mill with an impersonal number attached, or he is handled according to the clinician's concept of "what is best for him" irrespective of individual feelings. Lately, there has been a trend in the direction of minimizing the "art" of psychotherapy because of a rigid devotion to the "science" of psychotherapy. The personal factor in human relations is still perhaps the most important in spite of the value of great scientific contributions. The clinician who thoroughly understands and ministers to the subtle needs and feelings of the patient will inevitably be more effectual than the one who is rigidly impersonal and scientific. Symptomatic treatment is an important tool in the therapeutic armamentarium and merits the most careful attention.

The value of symptomatic treatment may be illustrated in connection with the large group of constitutionally inadequate psychoneurotics who constitute a very difficult problem for anyone who attempts to deal with them. These patients suffer from a wide variety of functional complaints that no treatment seems to help. They move from doctor to doctor, being treated by all known methods to no avail. They are very demanding of the time and attention of the doctor, but it is also almost impossible to satisfy their needs. As a prerequisite for any major plan of therapy, it may be necessary for the clinician to plan to provide enough attention and sympathy to satisfy their needs for emotional support. Nothing can be accomplished if the clinician is impatient and so heedless of clients' needs that he loses rapport and drives them to another counselor.

Masterful Inactivity

In clinical situations in which it is desirable to recognize the existence of pressing complaints about which it seems wise to

do nothing, the clinician can usually delay definite action through a plan of treatment that alleviates the anxiety of the client without actually accomplishing anything. There are many different methods whereby definite action is postponed without disturbing rapport with the client or losing his confidence.

Perhaps the simplest technique of inactivity is to recognize a complaint by giving vague assurance that action will be taken at some indefinite time in the future. The date for taking action may be indefinitely postponed by offering plausible explanation for the delay whenever the client seeks to precipitate some action. This method is used extensively with institutional inmates who desire to be discharged or to have some other temporarily unfeasible change made. Also, in institutions, in which theoretically all inmates have some chance for discharge, it may be desirable to stimulate good behavior by vaguely intimating that the inmate has some chance for discharge at an indefinite date which cannot be now determined. As long as the inmate considers himself to have even the slightest chance for discharge, he has some incentive toward good conduct.

Suggestion

Suggestion techniques have long constituted a basic method of palliation and are widely used in medical and psychiatric therapy today. The use of suggestion may be indicated when distressing symptoms are clearly of functional psychogenic origin. If the clinician clearly recognizes the indications and limitations of suggestion techniques, these techniques may be of value in obtaining enough symptomatic relief so that more basic therapy has a chance to operate. Here again, much of the dissatisfaction with suggestion as a therapeutic method has arisen from uncritical use without clear recognition that suggestion operates primarily on symptomatic levels as a palliative and exerts little or no effect upon deeper etiological factors.

Nondirective Methods

As Rogers (12) has pointed out, nondirective methods are primarily suited for the counseling of normal people and may not be useful with special groups, such as mental defectives, psychotics, severe neurotics, and the like. Such methods, however, may be used for palliative purposes with these special groups if it is clearly understood that no specific therapeutic action is expected. It may be extremely useful to handle the mentally disordered patient with nondirective methods until such time as rapport is established, the practical details of environmental regulation achieved, and the time becomes more suitable for the application of directive methods. It may be very convenient for the psychologist to assume a completely nondirective role until such time as utilization of other methods is indicated.

COMMUNICATION OF PSYCHOLOGICAL INFORMATION

One of the functions of the psychologist is to act as a consultant whose technical training enables him to be of assistance to those in need of reliable psychological information. Just as a lawyer furnishes legal information that may be valuable in conducting a business, so a psychologist should be competent to provide psychological information that is valuable to the normal person in regulating his affairs more effectively.

On the basis of broad training and experience in scientific psychology, the competent clinical psychologist possesses factual information that may be of value in solving human problems and supporting mental health. The question at issue concerns how this information may be imparted to the client in such manner that it is accepted and acted upon without threat to the client's personal integrity or mental health. Our experience with the criticisms that have been directed against directive therapy by proponents of non-

directive therapy, as represented by Rogers, has been that the imparting of factual information by a competent clinician does not inevitably (a) interfere with "client-centered" approaches to psychotherapy; (b) negate the principle of autonomous regulation of personality; (c) interfere with normal processes of growth and maturation; (d) arouse hostility or other undesirable negative personality reactions; or (e) interfere with such nondirective techniques as accepting, expressing, or clarifying feelings.

On the contrary, the judicious imparting of pertinent facts can be of great value in facilitating and supplementing other techniques. If major criticism is to be directed against imparting information, it should be on the grounds that such information can only be as valid as the experience and clinical judgment of the psychologist make it. Much of the criticism that has been directed against psychologists in the past is related to their *inexpert* use of valid methods.

The Client's Resources

In assessing the client's resources, one of the first decisions should be concerned with the client's ability to solve his problems through utilization of his own inner resources. For practical purposes it seems convenient to establish a general rule that the more seriously ill or defective a patient, the more necessary it becomes to utilize directive methods that supplement his inadequate resources until such time as he again becomes capable of intelligent self-regulation. If the client's personality resources are intact and his factual knowledge adequate, nondirective methods may suffice. If the client lacks the factual information necessary for the solution of his problems or if serious degrees of defection or disorder are present, there is clear indication for such directive methods as are necessary to provide resources adequate for handling of the situation.

Whether or not the client is able to verbalize his needs objectively, a normal person usually seeks consultation with the psychologist to obtain information or relief from symptoms that he has

been unable to obtain by himself. The experience of the psychologist will determine how quickly and adequately these needs are diagnosed and remedied. It is frequently possible, on the basis of broad clinical experience with similar personality types and situations, for the psychologist to diagnose areas of maladjustment from his evaluation of the resources of the organism as a whole without any actual knowledge of past history. For example, recognition of the fact that a client is constitutionally inadequate, physically unattractive, and ineffectual in expression and action immediately suggests to the psychologist that the client's difficulties are probably related to the frustration and feelings of inferiority commonly experienced by this type of personality.

Evaluation of Emotional Status

An attempt should be made to differentiate between primary emotional states that are related to temperament or affective disorders and emotional states that represent personality reactions to more fundamental etiological factors. *Reactive* emotional states are generally thought to have a better prognosis and to resolve themselves spontaneously when the primary stimulus is removed. Affective disorders and idiosyncrasies of temperament are much more difficult to deal with and require special techniques—usually psychiatric in nature. The significance of this differentiation for the psychologist lies in the fact that his diagnosis of the emotional state will determine his choice of therapeutic method. If the client is simply emotionally upset in reaction to his failure to solve nonemotional problems, it may suffice to recognize, accept, and clarify these feelings and then proceed to impart the information concerning the nature and causes of emotional upsets, how other people have handled similar problems and other information that scientific psychology may have to offer concerning self-understanding.

In cases in which emotional states represent constitutional personality reactions to problems, it seems obvious that recognition and clarification of feelings operate only on symptomatic levels and that

attention must be directed to primary etiological factors. Well-chosen directive methods are frequently effective in alleviating primary nonemotional causes of maladjustment, following which emotional reactions spontaneously disappear regardless of whether symptomatic treatment is given. It is necessary to do more than to uncover sources of conflict and etiological factors underlying maladjustment. This dynamic therapy of Rank attempts to go beyond the Freudian principle that "knowledge is curative, that the making conscious of the unconscious cures the neurosis (11, p. 106)." After recognizing and clarifying feelings and conflicts, it is usually necessary to go beyond the stage of understanding and elaborate a constructive plan for future action. Sometimes the client can work this out for himself but frequently matters are facilitated by imparting valid psychological information concerning such problems.

The Client's Attitude

The choice of methods to be used in imparting information depends primarily upon the intellectual and emotional attitudes shown by the client during the counseling interviews. The psychologist will usually be able to sense (a) whether the client comes for counseling of his own volition or at the request of others; (b) whether his attitude is genuinely receptive or whether cooperation is only superficial; (c) whether emotional states are interfering with receptiveness and must be dealt with first; (d) whether unhealthy ego drives causing negativism and resistance are present; and (e) how quickly and readily the client can assimilate and act upon what he is learning. The psychologist can rarely follow any preconceived schedule of his own; instead, he must adjust the program and tempo to the developmental progress of the client. The counseling must be client-centered, with the psychologist interjecting only as may be needed to keep the client headed in constructive directions. Progress will be irregular, the client occasionally remaining on a plateau for longer or shorter periods until some further insight is achieved.

Exploration of Alternative Courses of Action

The inexperienced counselor is frequently tempted to dissuade a client from unwise courses of action through direct prohibitions, authoritative pressures, or regulatory advice. After the counselor finds that the client ignores such crude directive measures and stubbornly adheres to his own course, he learns to utilize more subtle and indirect methods of influencing behavior. A more effectual method is that which seeks to stimulate the client to explore for himself the possible advantages and disadvantages of several alternative plans by providing information that will enable him to evaluate the various possibilities rationally. The client has frequently been unaware that other possibilities exist or he has been blocked by such personality factors as unhealthy emotional states. On the basis of psychological knowledge of effects and consequences, the counselor is frequently able to impart information that helps the client reach his own solution. Once the client recognizes that the counselor is not assuming an authoritarian, judgmental attitude but is merely offering his experience as an aid to rational discussion, the client usually drops his negativistic defensive attitude and begins to regard his problems as interesting objects for study. A common counseling situation is that in which it seems wise to dissuade a client from embarking upon an unwise course of action which threatens his entire security.

We have found these methods to be especially effective in counseling intelligent college students who are apt to commit foolish acts because of youthful indiscretion and optimism. Frank discussion and controversial plans for action are readily accepted if the student respects the counselor and learns that psychological viewpoints are valuable in solving life's problems.

Communication of Critical Attitudes

Whether he wishes it or not, every counselor is frequently called upon to intervene in situations that involve authority or dis-

ciplinary action. Especially in institutional and educational positions is the psychologist referred to when other methods have failed and the urgency of the situation requires immediate concrete action. One situation of this nature is that in which it becomes necessary to communicate to a person the critical attitudes of others about him. It may seem desirable to influence a person to alter his conduct completely and immediately in order to avoid the displeasure and retaliatory action of his associates. The quickest way to accomplish the desired changes may be to give advice which, if accepted, would alleviate the most pressing maladjustments with a minimum of discomfort to all. Another method is to impart the necessary information in such a careful or subtle manner that the recipient does not take offense and is inclined to act up the advice.

Many children and extroverted persons have little insight into the fact of their maladjustment and little sensitivity to the critical attitudes of others. Far from being emotionally disturbed by their predicament, they blithely ignore critical attitudes and seem genuinely astonished to discover that others consider them behavior problems. It becomes the function of the counselor to impart the fact of critical attitudes and to assist the client in discovering alternative patterns of conduct that will be more socially acceptable. If the client can be led to face reality and take steps to correct his shortcomings, a desirable result may often be quickly accomplished.

Crises in Counseling

Most counseling situations are not critical in the sense that the most serious consequences will result unless drastic action is taken. Under average conditions counseling can be carried on smoothly without the need to make life-or-death decisions, and a leisurely, nondirective approach allows the client to work through his own solutions without advice or regulation from the counselor. Occasionally, however, in counseling critical situations arise in which it seems indicated that the counselor should act decisively in influencing the client to accept some definite plan for resolving an acute

emergency situation. If specific directive action seems indicated on ethical, moral, or psychological grounds, the counselor should not hesitate to influence the client to follow whatever plan of action seems to offer the best chances of avoiding serious maladjustment.

It frequently requires immediate and decisive intervention to protect the client from the possible disastrous consequences of his own impulsive action. Many of the cases reported in illustration of nondirective counseling methods have not involved acute maladjustment from which serious complications were impending, and there is therefore some question as to how adequate nondirective methods are in this type of case. What should the counselor do when he discovers that the client committed, or is contemplating the commission of, a serious crime? What should the counselor do when he discovers that his client, a fifteen-year-old girl, is illegitimately pregnant and is considering an abortion or some other drastic step? These and other decisive matters of technique require carefully controlled research for their solution. Our opinion is that in cases in which directive methods or intervention will almost certainly prevent the possibility of unwise action, it is not desirable to experiment with nondirective methods, which are much less certain in their probable outcome. Among his many obligations, the counselor must protect the immature young person or the emotionally unstable adult from the potentially disastrous results of lack of judgment and impulsiveness.

Details of Methods

There are innumerable methods for imparting information which, evidently, the client should learn. If it does not seem tactful to *tell* him directly, numerous devices can be arranged to enable him to *find out* for himself. For example, he may be referred to books, study courses, and other sources of reliable scientific information. If he is a member of a lecture class or is undergoing group therapy, matters can be discussed impersonally by means of suitable illustrative cases. If he is a well-integrated extrovert, he can be told bluntly, whereas a sensitive introvert may need to be led slowly

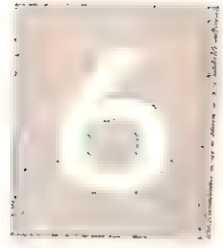
and indirectly to self-realization. Whatever the method used, facts should be carefully selected and objectively presented. Every effort should be taken to maintain an impartial, nonjudgmental manner of presentation devoid of personal emotional attitudes which might stimulate negativistic defensive reactions in the client.

The status of all methods of psychotherapy is in such an elementary stage of evolution that clinical psychologists find themselves in a position similar to that of the chemists who have discovered some of the rarer elements but do not know what to do with them. Some of the neglected methods, such as suggestion, hypnosis, reconditioning, or reassurance may well turn out to have as startling possibilities in their way, when properly used, as did uranium. When psychologists devote as much time and energy to training themselves in the use of any of these methods as do professional athletes or craftsmen, much of the crudeness that is now so much in evidence will inevitably disappear. Some cases will show improvement after the use of any superficial method, but others become progressively more maladjusted and constitute a problem that will require the most effective use of all resources if it is to be solved. Directive psychotherapy requires the therapist to be trained and able to make use of every known method of his field.

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Psychodrama

J. L. Moreno

Recognized as the creator and foremost exponent of psychodrama, Dr. Moreno was graduated from Vienna University with the M.D. degree in 1917 and in 1927 was licensed to practice medicine in New York State. He is founder of the Psychodramatic Institute, Beacon, N.Y. and has been a consultant in developing psychodrama theaters in many universities and in government and private hospitals. He is the founder also of the journal *Group Psychotherapy* and has written many articles and books in the field of psychodrama, sociodrama, and psychomusic.

Dr. Moreno traces psychodrama historically to the principle of play, and specifically to one of his own play experiences at the age of four. However, he writes, psychodrama was born on All Fool's Day, April 1, 1921, between 7 and 10 P.M., when he gave a one-member cast performance in a Vienna theater, the *Komoedien Haus*. The same year he developed in Vienna the first therapeutic theater, the Spontaneity Theater. Out of his work in this theater and his book *Das Stegrieftheater* (1923) developed psychodrama as we know it today.

Defining psychodrama as "the science which explores the 'truth' by dramatic methods," Moreno employs in his method such techniques as *tele relation*, a complex of feelings, drawing one person toward another, which is aroused by the real attributes, individual or collective, of the other person. Other techniques include *primary ego*, the patient; *auxiliary ego*, a therapeutic agent, that is, another person who provides assistance for and extends the primary ego by identification and represents the other person—the absentee; *spontaneity*, the response of an individual to a new situation, and the new response to an old situation; and *warming up*, physical activities and forced moods which allow the patient to work up to spontaneity. He states that psychodrama is a method of diagnosis, as well as a method of treatment, adaptable to every type of problem, personal or group, with children or adults.

Psychodrama

THE USE OF psychodrama is a novel form of psychotherapy, but one that can be applied widely. Psychodrama puts the patient on a stage where he can work out his problems with the aid of a few therapeutic actors. It is both a method of diagnosis and a method of treatment. One of its characteristic features is that role-acting is organically included in the treatment process. It can be adapted to every type of problem, personal or group, of children or of adults. It can be applied at every age level; problems at the nursery age as well as the deepest psychic conflicts can be brought nearer solution by means of it. Psychodrama is human society in miniature, the simplest possible framework for a methodical study of society's psychological structure. Through techniques such as the auxiliary ego, spontaneous improvisation, self-presentation, soliloquy, and the interpolation of resistance, new dimensions of the mind are opened up and, what is more important, can be explored under *experimental* conditions.

Psychiatry may be divided into three categories: *confessional* psychiatry, *Shakespearean* psychiatry, and *Machiavellian* psychiatry. An illustration of confessional psychiatry is psychoanalysis. An illustration of Shakespearean psychiatry is psychodrama, which heals and explores the truth by means of dramatic methods. It is called "Shakespearean" because Shakespeare, more than any other, has contributed, not to this form of therapy, but to its content. Illustrations of Machiavellian psychiatry are electric-shock therapy, insulin-shock therapy, and lobotomy. They are named for Machiavelli because he advocated some of the cruelest methods in the government of human affairs on the basis that the end justifies the means.

Among the three categories, psychodrama is in a strategic position, because it brings the three efforts into a synthesis. After the study of heredity, of anatomy, of physiology, of internal medicine, of histology, of neurology; after psychoanalysis and even after lobotomy, one must enter the process of living itself, living in a world full of unknown opportunities and boundaries—or at least full of uncertainties; a world ever changing, filled with unknown objects and people. After knowledge has been acquired, a finishing touch is needed; one still needs to learn how to live. This is what psychodrama and its allied methods and techniques propose to do for individuals: to provide them with the science and skills of living, with a "life practice."

HISTORICAL DEVELOPMENT OF PSYCHODRAMA

Historically the psychodrama grew out of the principle of play. Play is older than man; it has accompanied the life of organisms as one of its excesses, anticipating growth and development. In our culture Rousseau and Froebel especially directed attention to the educational value of play. But a new vision of the principle of play was born when, in the years before the outbreak of the First World War, I began to play with children in the gardens and streets of Vienna. Here play was considered a principle of cure, a form of spontaneity, a form of therapy, and a form of catharsis; it was regarded not only as an epiphenomenon accompanying and supporting biological aims but as a phenomenon *sui generis*, a positive factor linked with spontaneity and creativity. Play has gradually been separated from its metaphysical, metabiological, and metapsychological connections and shaped into a methodical and systematic principle. All this has brought the idea of play to a new and heretofore unknown universality. It has pushed and inspired the development of play techniques, play psychotherapy, theater of spontaneity, therapeutic theater, all culminating in the role playing, psychodrama, and sociodrama of our time.

After the Viennese "garden revolution," the opening of the first therapeutic theater—the Spontaneity Theater—in Vienna (1921) was the greatest triumph of the play principle. Supplemented two years later by my book, *Das Stegrieftheater*,* the play principle signaled the surpassing of psychoanalysis by the revolutionizing of the *vehicle*, *form*, and *concept* of treatment. The psychoanalytic vehicle was the couch. In psychodrama the antiquated couch was transformed into a multidimensional stage, giving space and freedom for spontaneity, freedom for the body and for bodily contact, freedom of movement, action and interaction. Freud's free association was replaced by psychodramatic production and audience participation, by action dynamics and dynamics of the groups and masses. With these changes in the research and therapeutic operation, the framework of psychoanalytic concepts—sexuality, unconscious, transference, resistance, and sublimation—was replaced by a new, psychodramatic, and sociodynamic set of concepts—the spontaneity, the warming-up process, the *tele*, the interaction dynamics, and the creativity.

These three transformations in vehicle, form, and concept transcended but did not eliminate the useful part of the psychoanalytic contribution. The couch is still there in the stage, which is like a multiple of couches of many dimensions—contributing height, width, depth; sexuality is still in spontaneity; the unconscious is still in the warming-up process; transference is still in the *tele*. There is one phenomenon, creative productivity, for which psychoanalysis has no counterpart except the defective one of sublimation. Because of the extremely dialectic character of this century, arising from the transition from one type of culture to another, this change in concepts and operations is hidden, insidious, and Machiavellian in itself.

* *Stegrieftheater* means theater which is dedicated to the spontaneous drama and derives its meaning from the German word *stegrief*. This term, *stegrief*, is difficult to translate and has such meanings as "stirred up," "warming up quickly," "get started," and "acting on the spur of the moment."

THE DYNAMICS OF PSYCHODRAMA THERAPY

The place of dynamics in psychodrama is often misunderstood. The logic of psychoanalysis is to take advantage of the transference of the patient, to work through his resistance to the return of the repressed to consciousness. The logic of psychodrama is different and more complex because of the novel elements that enter into it. The transference to the therapist exists here, too, but the relation is far more realistic, often assuming the character of a real battle between therapist and patient. The patient feels far more threatened, because the therapist wants so much more from him; the therapist wants him not only to speak freely but to expose his whole inner drama in action and words that are his own and also those of people who are closest to him and whose secrets he fears to reveal. As a result, the patient tries to put up a fight, as if against an attack. The therapist, in turn, is not the quiet, passive listener of psychoanalysis; he must put up a good battle in order to get the patient to produce. The transference, therefore, at times begins from the *therapist's* side and is overwhelming in character. The therapist wants something from the patient immediately, but the patient refuses to yield.

This picture of an overwhelming resistance of the patient because of the therapist's need for an overwhelming resistance should not mislead the reader. In most cases the resistance against being psychodramatized is small or nonexistent. Once a patient understands the degree to which the production is of his own making, he will cooperate. It is obvious that here the concept of transference is being used in a way that goes far beyond the ordinary definition and changes its meaning.

In the psychodramatic situation the struggle between therapist and patient is extremely real. To a certain extent they must assess each other. Each must rely on his resources. Thus, the amount of projected transference that operates from the patient toward the therapist is pushed into the background or is greatly reduced. Positive factors that are shaping the relationship and interaction in the

reality of life itself take their place: spontaneity, productivity, the warming-up process, the *tele* and role processes.

But, because of the dialectic character of the psychodramatic methods, this first phase is rapidly terminated and replaced by another. The therapist, after his effort to get the patient started, recedes or fades from the scene; frequently, he takes no part in the psychodrama and at times is not even present. From the patient's point of view, his object of transference, the therapist, is pushed out of the situation, and the retreat of the therapist gives the patient the feeling that he is the winner of their struggle. Actually it is nothing but the preliminary warm-up before the big bout. To the satisfaction of the patient other persons enter into the situation, persons who are nearer to him, such as his own mother and wife, or individuations that are part and parcel of him, such as his delusions and hallucinations. He knows them so much better than this stranger, the therapist. The more they are in the picture, the more he forgets the therapist. And the latter wants to be forgotten, at least for the time being.

The dynamics of this forgetting can be easily explained. Not only does the director-therapist leave the scene, but the auxiliary ego therapists step in, and it is among them that the patient's share of *tele*, transference, and empathy is divided. In the course of the production it becomes clear that *transference is nothing by itself, but is the pathological portion of a universal factor, tele*, operating in the shaping and balancing of all interpersonal relations.

As the patient takes part in the production and warms up to the figures and figureheads of his own private world, he attains tremendous satisfactions which take him far beyond anything he has ever experienced. He has invested so much of his own limited energy in the images of his perceptions of father, mother, wife, and children, as well as in certain images that live a foreign existence within him in delusions and hallucinations of all kinds, that he has lost a great deal of spontaneity, productivity, and power for himself. The images have taken his riches away, and he has become poor, weak, and sick.

Now, the psychodrama gives back to the patient all the invest-

ments he has made in the extraneous adventures of his mind. He takes his father, mother, sweethearts, delusions, and hallucinations back unto himself, as well as the energies that he has invested in them. They return as he actually lives through the role of his father or his employer, his friend or his enemy; by exchanging roles with them he is already learning many things about them which life does not reveal to him. When he himself can be the persons he hallucinates, not only do the latter lose their power over him, but he gains their power for himself. His self has an opportunity to find and reorganize itself, to put together the elements that may have been kept apart by insidious forces, to integrate them, and to attain a sense of power and of relief, a "catharsis of integration" (as differentiated from a catharsis of abreaction). It may be claimed that the psychodrama provides the patient with a new and more extensive experience of reality, a "*surplus*" reality, a gain that justifies, at least in part, the sacrifice he has made by working through a psychodramatic production.

This second phase in psychodrama is gradually replaced by a third, in which the audience drama takes the place of the production. The therapist vanished from the scene at the end of the first phase. Now the production itself vanishes and with it the auxiliary egos, the good helper, and the genii who have aided the patient so much in gaining a new sense of power and clarity. The patient is now divided in his reactions: on the one hand he is sorry that it is all gone; whereas on the other he feels cheated and angry for having made a sacrifice, the justification for which he does not completely understand. He becomes dynamically aware of the presence of the audience. In the beginning of the session he was angrily or happily aware of it. In the warming up of the production he became oblivious of the existence of the audience, but now he sees it again, one by one, strangers and friends. His feelings of shame and guilt reach their climax.

However, as the patient was warming up to the production, the audience before him was also warming up. But when he came to an end, they were just beginning. The *tele-empathy-transference* com-

plex undergoes a third realignment of forces; it moves from the stage to the audience, initiating intensive relations among the audio-egos. As the strangers from the group begin to rise and relate their feelings about what they have learned from the production, he gains a new sense of catharsis, a group catharsis; *he has given love and now they are giving love back to him*. Whatever his psyche is now, it was molded originally by the group, and by means of the psychodrama it returns to the group. The members of the audience are now sharing their plights with him as he has shared his with them.

The description would not be complete if the roles that the therapist and the therapeutic egos play in the warm-up part of the session were not discussed briefly. Since this aspect has numerous versions, the discussion here will be limited to their roles in the treatment of mental disorders, especially in the psychoses, for it is in the treatment of the psychotic personality that psychodrama has accomplished some of its most amazing results. The theoretical principle is that the therapist acts directly upon the level of the patient's spontaneity (obviously it makes little difference to the operation whether one calls the patient's spontaneity his "unconscious") and that the patient enters actually the areas of objects and persons, however confused and fragmented, to which his spontaneous energy is related.

The psychodrama therapist is not satisfied, as is the analyst, to observe the patient and to translate symbolic behavior into understandable, scientific language. Rather, he enters as a participant-actor, armed with as many hypothetical insights as possible, into the spontaneous activities of the patient, to talk to him in the spontaneous languages of signs and gestures, words and actions, which the patient has developed. This is, of course, dangerous psychiatry. Psychodrama does not require a theatrical setting (a frequent misunderstanding); it may be done *in situ*, that is, wherever the patient is found. According to psychodramatic theory a considerable part of the psyche is not language-ridden. It is not infiltrated by the ordinary, significant language symbols, and it assumes that these silent parts of the

psyche play a great role in the development of the psychoses. Therefore, bodily contact with such patients, if it can be established through touch, caress, embrace, hand shake, sharing in silent activities, eating, walking, or confused activities, is an important preliminary to psychodramatic work itself. Bodily contact, body therapy, and body training continue to operate in the psychodramatic situation.

An elaborate system of production techniques has been developed by means of which the therapist and his auxiliary egos push themselves into the patient's world, populating it with figures extremely familiar to him, with the advantage, however, that they are not delusionary but half-imaginary, half-real. Like good and bad genii, they shock and upset him at times; at other times they surprise and comfort him. He finds himself, as though trapped, in a near-real world. *He sees himself acting; he hears himself speaking. But his actions and thoughts, his feelings and perceptions do not come from him; they come, strangely enough, from another person, the therapist, and from other persons, the auxiliary egos, the doubles and mirrors of his mind.*

It may be enlightening here to quote Ferenczi, who is usually referred to as the author of active therapy in psychoanalysis, placing his statements alongside parallel quotations from my own writings. In order to indicate the contrast as clearly as possible, quotations from the most characteristic writings of both authors, which appeared at approximately the same time, have been selected.

From S. FERENCZI (1921):

The fundamentals of psychoanalytic technique have undergone little essential alteration since the introduction of Freud's "fundamental rule" (free association). . . . For most patients the treatment can be carried out without any special "activity" on the part of either doctor or patient, and even in those cases

From J. L. MORENO (1919):

If you . . . would produce your dramas on this stage they would exert upon you, the original and permanent hero, and everyone in the audience a comical, liberating and purging effect. In playing yourself you see yourself in your own mirror on the stage, exposed as you are to the entire audience. It is this

in which one has to proceed more actively the interference should be restricted as much as possible. . . . Psychoanalysis as we employ it today is a procedure whose most prominent characteristic is passivity. (See *Theory and Technique of Psychoanalysis*, p. 198, 199.)

From S. FERENCZI (1925):

One should not employ activity if we can assert with a good conscience that all available methods of the not-active (the more passive) technique have been brought into use. . . . The analyst is therefore first and last inactive and independent and may only occasionally encourage the patient to do particular actions. (*Op. cit.*, pp. 220, 224.)

[The kind of activity Ferenczi refers to is exemplified, for instance, in the case of a patient who keeps her legs crossed during analysis on the couch. He, Ferenczi, forbids the patient to adopt this position because in so doing she is carrying out a larval form of onanism. (*Op. cit.*, p. 191.)]

mirror of you which provokes the deepest laughter in others and in yourself, because you see your own world of past sufferings dissolved into imaginary events. To be is suddenly not painful and sharp, but comical and amusing. All your sorrows of the past and present, outbursts of anger, your desires, your joys, your ecstasies, your victories, your triumphs have become *emptied* of sorrow, anger, desire, joy, ecstasy, victory, triumph, that is, emptied of all *raison d'être*. (See "Die Gottheit Als Kommoediant," *Daimon*, April, 1919, Vienna. Trans., *Psychodrama*, vol. I, p. 24.)

From J. L. MORENO (1923):

The persons play themselves . . . they do not want to analyse reality, they bring it forth. They produce it, they are master; not as fictitious beings but their true existence. . . . The whole of life is unfolded, with all its mutual complications . . . not one instance is extinguished from it, each moment of boredom is retained, every moment of inner withdrawal comes back to life. Here total production of life is brought into view, not total analysis. (*Das Stegrieftheater*, pp. 90-91.)

The ideal objective of psychoanalytic therapy is *total analysis*. It aims to give the patient more analytic insight than the routine of living activates in him spontaneously. The objective of psychodramatic therapy is the opposite: it is *total production* of life; it tries to provide the patient with more reality than the struggle with living permits him to achieve spontaneously, to provide a "surplus" reality. The excess of life realization helps the patient to gain control and mastery of self and world through practice, not through analysis. Analysis occurs and is given to the patient whenever necessary, but it is an adjunct to psychodrama and not the primary source of catharsis.

INTERPERSONAL THERAPY

One of the great problems in mental therapeutics is what method may be used to start the patient expressing himself. This is a crucial problem even with a patient who has a physical disease; the patient has to describe his pains and other experiences related to it, and he may hesitate or put emphasis on insignificant details. It is a part of the physician's skill to start a patient off in the proper direction, so that he may give as precise and objective a description of his condition as possible. This task becomes imperative in the case of psychiatric patients. The patient with catatonic behavior may not be able to get started at all without outside aid, and the maniacally excited patient may go off on a tangent that is not amenable to suggestion and guidance.

In all psychotherapeutic situations practiced thus far, the patient is treated in isolation. He describes with words how he feels about his own problems. But in interpersonal therapy, especially in the form of psychodrama, the task is still more complicated. Here the patient must be made to express how he feels at present, not only through words but through gestures and movements. He must act not only in the role of his immediate situations but in roles contrasting with his actual aspirations. He must live through situations

that are painful and undesirable and present roles that are obnoxious to him, and he must act with partners whom he loves and admires or whom he fears and rejects. These conditions in the psychodrama have forced a reconsideration of the function of the psychiatrist as well as of the function of the patient.

The function of the psychiatrist began to disturb some people in the field years ago, at the time that the therapeutic theater was first used for patients. In his professional capacity, the psychiatrist has to restrain and discipline himself to appear always in the role in which he is expected to appear and for which he is employed, the role of the doctor and healer. He cannot leave the role of the doctor and act as a lawyer or salesman. The more inflexibly, the more rigidly and obediently he sticks to his role, the higher is his conduct to be commended. Furthermore, even within the role, in the situations in which the doctor meets the patient, many formalities that keep the situation rigid and the doctor at a certain distance from the patient are involved. This pattern of conduct has to be carefully weighed before being altered, even though there may be an imperative reason for the change.

This imperative reason seems to be found in the treatment of a certain group of mental patients who are inadequate in many of the roles in which they act in life—as sexual partners, as work associates, as social companions—and who are alone in their isolated thoughts. Until now the psychiatrist treating a patient in his office may touch upon and disclose all these roles in the course of his treatment. But, however extensively considered they may be, all roles and situations remain in the patient's mind. In the office situation the sexual partner remains fictitious (that is, something to be imagined), just as the sexual role that the patient feels in himself remains fictitious. Similarly, the work associates remain fictitious, as does the patient himself as a working ego. Other roles and situations that he may feel and his interrelations with other persons in various roles also remain unenacted.

The patient does not move out of himself to incorporate the roles and situations in which he has failed; thus, the true reality tests

are never faced by him in the course of, and as a part of, the treatment. The patient may become angry with the psychiatrist or may feel attracted to him as a person; but the patient may not fight with the psychiatrist or express intense love for him. All these remain in the feelings of the patient. The silent drama does not become actual. It is not only that the patient cannot live through the roles and situations before the physician; the psychiatrist himself is limited by the situation in which he is placed. He cannot move toward the patient, get angry, or make love. He is prohibited by a self-imposed pattern of conduct. He cannot transcend his own situation and act a part, even though the patient needs it badly. He cannot become a spontaneous actor, for in order to do so, he would have to give up the accepted, laboriously learned theories and techniques of analytical treatment and resort to *spontaneous techniques in the treatment of mental disorders*. It is this broader conception of the role of the psychiatrist that we shall discuss.

MENTAL CATHARSIS

The Greek word *therapeutes* means "attendant" or "servant." The earliest therapeutic measure was devoted to driving out the demons from the bodies of the victims, the method usually consisting in the reciting of charms or magic over the ailing parts or over the sick person as a whole. Since the patient was not able to drive out the demon himself, he needed an attendant, or servant, a *therapeutes*. The recital of magic or charm over the sick person was performed by a priestly man, a primitive counterpart of the principal therapeutic actor, the auxiliary ego, in a theater for the psychodrama. The drama, long before it was a place for presentation of art and entertainment, was a place for therapeutics, the sick coming to it for catharsis.

In his *Poetics* Aristotle defines catharsis as follows: "The task of the tragedy is to produce through the exercise of fear and pity liberation from such emotions." Aristotle expected the catharsis to

take place in the spectator. The modern point of view as explored by me is in contrast to Aristotle's. The mental catharsis is expected to take place in the actor, in the mind of the person who is suffering from the tragedy. The place of catharsis has moved from the spectators to the stage. Now the actors are the patients; they need catharsis, liberation from the tragic conflicts and the emotions in which they are caught.

But if the actors are the subjects of the catharsis, then the whole process on the stage must be reconsidered. Aristotle's tragedy was a *finished* work, finished by an author, an outsider, long before it was enacted, and it had no relationship with the personal make-up of the actors. Clearly, the tragedy, to be truly cathartic material, must be created by the actor-patients themselves out of their own psychic materials—not by a playwright. The actor-patients can of course become authors of their own dramas and rehearse them ahead of time. These dramas may give better insight into the personal problems, but the actual presentation of such a drama on the stage after weeks or months of labor and censoring and erasing of material would add little or nothing to the mental catharsis already attained by the writing itself.

There is one more step. Not only the author but also the finished tragedy of Aristotle must be discarded. The actor-patients should have no product to start with. They should develop their drama on the spur of the moment. The problems portrayed, whether they are their own personal problems or whether they are fictitious, have to be shaped as they emerge spontaneously. The possibilities of insight and mental catharsis are then practically unlimited. In place of Aristotle's tragedy we have the *psychodrama*.

With the advent of psychodrama, the problem of mental catharsis has changed. As in a tragedy, the participants in a psychodrama may be numerous. The catharsis in one person is dependent upon the catharsis in another person. *The catharsis has to be interpersonal*. Since the course of interaction between the persons is purely spontaneous, the amount of maladjustment between them will become evident as well as the amount of mental catharsis attained.

THE PSYCHODRAMA

A study of the first experimental device, which was constructed in the early days of *stegrief* work, from the therapeutic angle alone should be enlightening. In the pretherapeutic, purely dramatic phase, the momentary structure of a situation and the means of getting the individual started so that he might throw himself into that momentary state were the primary concerns. The momentary structure of a situation for spontaneous dramatic purposes, whether suggested by the director or the actor himself, consisted of an imagined situation carefully specified, a role for the individual actor, and a number of personified roles by other actors needed to bring the momentary structure to as clear and dramatic an experience as possible—all this to be brought into action on the spur of the moment.

The momentary private-life situation of the actor, his private personality, and the actual strivings and conflicts, which were for him just in the process of development, were less emphasized in the dramatics classes, though they became of especial concern in mental therapeutics. Then the momentary structure of the patient's private-life situation, the physical and mental make-up of his personality, and, most of all, the manner in which he operated and interacted at that moment with members of his family and with various members of his "network" comprised the information needed for diagnosis.

More accurately, this information was needed by the patient and his auxiliary ego, the psychiatrist, in order to devise some vehicle of autonomous treatment and cure. It was realized that he must have charged all persons and objects in his immediate environment with some aspect of himself and that this must be traceable in the performance of his bodily and mental functions, in his inner tensions preliminary to these performances, in his gestures and expressions, in the words associated, and in the feelings and movements toward the persons and things with which he lived. In the more complex forms of social neurosis, in which two, three, or more per-

sons were to be treated simultaneously, the scenes enacted by them became a formidable pattern for treatment. Finally, all the scenes in their remote past and all the remote networks became important from the point of view of a general catharsis of all the people involved. The solution was then the resurrection of the whole psychological drama, or at least of the crucial scenes of this drama, re-enacted by the same persons in the same situations in which their association had begun.

The new technique, if properly applied, aided the patient to actualize during the treatment that part of his past life which he needed to re-experience. He had to meet the situations in which he acted in life, to dramatize them, to meet situations that he had never faced, that he had evaded and feared but might have to meet squarely one day in the future. It was often necessary to magnify and elaborate certain situations that he was living through sketchily at the time or had only dimly recollected. The chief point of the technique was to get the patient started, to get him warmed up so that he might put his psyche into operation and unfold the psychodrama.

A technique of spontaneous warming up to the mental states and the desired situations was developed. The spontaneous states attained through this technique were feeling complexes and as such were useful guides toward the gradual embodiment of roles. The technique demanded usually more than one therapeutic aid for the patient, such as aids to start off the patient and representatives of the principal roles that the situation and the patient might require. Instead of one ego, numerous auxiliary egos were needed. The result was that the original auxiliary ego, the psychiatrist, remained at a distance but surrounded himself with a staff of auxiliary egos whom he coordinated and directed and for whom he outlined the course and the aim of psychodramatic treatment.

THE PSYCHODRAMATIC METHOD

Procedures of the treatment may be *open* or *closed*. The open treatment is carried out in the midst of the community, more or less with the full knowledge of, and eventually with the participation of, the group. Treatment for sociometric assignment is an illustration of open treatment. It is treatment *in situ*; that is, the scene of treatment for the patient is the same as the scene for his living. The essence of sociometric treatment is that the social situation and the therapeutic situation of the patient are one and the same.

The surgical operation is an illustration of closed treatment. The patient is removed to the hospital, and only the surgeon and his assistants participate in the operation. Similarly, the psychodramatic treatment is at times closed. The patient is taken out of his immediate environment and is placed in a situation especially constructed for his needs. The therapeutic theater is such a situation. It is a world in miniature, a place in which, through psychodramatic means, all situations and roles that exist, or may exist, in the world are enacted. The situation is closed, because there is no room for spectators other than the community of auxiliary egos. Only the psychiatrist and a number of assistants who are assigned to principal roles in the course of the treatment are in the theater. Some forms of psychodrama, however, are wide open, as, for example, when the audience is made up of numerous subjects sharing in the same mental or cultural syndrome. The audience, however large, is then like a collective patient consisting of individual components.

The staff of therapeutic assistants should be as large as possible, should contain members of both sexes, and should vary widely in personality types. This staff of auxiliary egos is informed of the specific situations in which the patient may act. The patient at first mixes freely with all the members of the staff and has an opportunity to become acquainted with everyone. He may be attracted to some and repelled by others. He is allowed to choose the role and the

assistant with whom he would like to act out the situation. The *tele* relations of the patient are thus our first guide. The patient is allowed to carry out his personal aims to the extreme. Every situation and performance is analyzed immediately after the performance in the presence of the patient and with his collaboration. After a number of situations chosen by the patient have been enacted, it may become evident that he tries to avoid scenes and roles that are painful and unpleasant. Then it becomes necessary to tell him in what situations and in which roles he should act.

The therapeutic approach differs from the artistic approach in this one essential factor—it is concerned with the private personality of the patient and his catharsis and not with the role represented and its aesthetic value. However, it will be evident later that the therapeutic and aesthetic domains cannot remain separated, that they have a definite interrelationship.

When psychodramatic principles are applied to art, especially in the theater, it can be observed that the presentation of the role is often interrupted by foreign elements, which betray the private personality of the actor and many of his own traits and desires. The spontaneous character of psychodramatics makes it difficult, almost impossible, for the actor to keep his private ego out of the role, and he is perhaps continually forced to mix the private-role elements with the collective-role elements so skillfully that no one can distinguish them. When a role is rehearsed, as in the theater, these adjustments can be made with more artistry, and a gradual elimination of all the painful, unpleasant elements incongruent to the role can take place. It is just the imperfection of the individual in psychodramatics that makes psychodrama invaluable for the analysis of personality.

The role may be defined as a unit of synthetic experience into which private, social, and cultural elements have merged. Since time immemorial the theater has been the setting of role acting. In the drama the platonic idea of the role was cultivated in its pure form, unadulterated by the fragmentariness and complexities of real living. It was plausible, therefore, that psychodramatic theory should redis-

cover the role phenomenon, and it was the psychodramatist's good fortune to open for the role process the gates to experimental and clinical foundation. Thus the psychodramatist was able to render a service to the sociologist and social psychologist, who were trying in vain to give a tangible and scientifically verifiable basis to the process of role taking. Every psychodramatic session demonstrates that *a role is an interpersonal experience* and needs usually two or more individuals to be actualized.

PSYCHODRAMATIC TREATMENT OF MENTAL PROBLEMS

Technique of Self-presentation

The simplest psychodramatic technique is that in which the patient starts with himself; that is, in the psychiatrist's presence, he lives through situations that are a part of his daily life and especially through crucial conflicts in which he is involved. He must also enact and represent as concretely and thoroughly as possible every person near him and near his problems: his father, his mother, his wife, or any other person in his social "atom." * The patient does not present "roles" this phase of the treatment. It is not *the* father, *the* mother, *the* wife, or *the* employer; it is *his* father, *his* mother, *his* wife, *his* employer.

The patient is aided by a member of the staff in getting started, but the auxiliary ego remains outside the situation. The auxiliary may be outside the enacted situation, but he is not outside the total situation; he is in the theater and is one in front of whom the patient acts. The *tele* relationship of the patient with his auxiliary ego has a definite bearing on the structure of the psychodramatic

* The social atom is the nucleus of all individuals toward whom a person is emotionally related or who are related to him at the same time. It is the smallest nucleus of an emotionally toned interpersonal pattern in the social universe. The social atom reaches as far as one's *tele* reaches other persons. It is therefore also called the "*tele* range" of an individual. It has an important operational function in the formation of a society.

presentation. He watches the patient as he acts, encouraging and commenting. At times the patient stops and explains his acts to him. The patient may act the same situation in a different manner to a man and to a woman, to a person attracted to him and to a person indifferent to him.

The presentation may relate to situations past, present, or future. The patient is asked not merely to portray situations that he has lived, but to duplicate them completely. He is asked also to portray these situations with as much detail as possible and, if necessary, in collaboration with a partner. If, in these situations, he is a lone character he may psychodramatize them alone, but if he has certain concrete partners in mind—his wife, his friend, or someone else—then it is desirable to have these imagined concrete partners present and work out the situation with him on the stage. If the concrete person he imagines is not available, he is asked to pick from among the persons present someone he imagines resembles the partner. If the patient has dreams, he is asked to psychodramatize the dream as accurately as possible. It is desirable that the patient be prepared by the psychiatrist or by another auxiliary ego for these projected situations.

Technique of Spontaneous Improvisation

Spontaneous improvisation is a technique in which the patient does not enact events from his own life, but acts in fictitious, imagined roles. Here an auxiliary ego has a double function: on the one hand he acts as a starter who gets the patient working in a specific role, while on the other he is a participant actor in a role that the situation demands. The patient warms up to various roles which he may have wished to represent in life but which have been frustrated. He acts opposite various people in symbols and roles that are either pleasurable or painful to him. These people in different roles project their own personality at him. The procedure becomes a significant test of the patient's behavior in his various interpersonal relationships, however much he may try to avoid it. Many elements

of his private personality enter continuously into his fictitious roles and offer an open target for analysis.

In spontaneous improvisation, the task is in one respect the reverse of that in self-presentation. Here the subject tries to *prevent* his private character from interfering and from mixing with the fictitious character. The struggle, competition, and eventual collaboration of the two, the private and the fictitious character, are visible in every portrayal. The ambiguity of presentation is full of clues for the study of a person. Two of the factors producing the ambiguity of a role are the private feeling of a patient for his partner and the desire to dominate the situation and to develop not only his role but also the role of his partner. This latter mechanism produces at times a private struggle between the two partners, an ambiguity in their relationship, which interferes with the roles to be presented and sometimes shapes them into a pattern that contrasts greatly with the original intention. Another factor is the private feeling of the subject for the persons watching the performance in the audience. The most important analytical task in this procedure is to distinguish carefully between the private ego material projected into the character of the role and the fictitious content of the role itself.

When a person is entirely absorbed by a role, no part of his ego is free to watch it and so to record it in his memory. He is as a man in a dream. Even the functioning of his memory becomes involved in the task of developing the role. It has often been suggested to individuals who had a great selective affinity for a certain role and also for the partners with whom they worked that they try to register as much as possible of the inner and outer events. The experiments had the following results: the more the individual tried to act and to watch himself at the same time, the more he was in danger of failing in his role. His effort was then broken up into two parts, the part that he did for the psychiatrist—to remember—and the part that he acted in the plot.

A return to the same mechanism in spontaneous improvisation is now in order. *The less absorbed an individual is in his role, and the weaker the spontaneous state, the more that part of his ego*

which watches the performance is able to disturb and to disintegrate the procedure. The individual performer has therefore to be careful not to let the desire for remembering interfere too much with the realization of the act.

The method of training the ego to do a double task, to think and to act simultaneously, is, however, within the practical possibilities. Numerous cases have been observed in which a subject had learned how to act a role and to register its content at the same time. However, when this private part of the ego becomes too active within spontaneous improvisation, it is responsible for numerous interpersonal disturbances. If the spontaneous state into which the subject throws himself is full and strong, it matters little. Even then he may develop an anxiety state—the anxiety of losing his presence in the role and in relation to his partner. The anxiety state increases in gravity if the performer has had a weak spontaneity state from the start and if his *élan* to carry the role for a sufficient length of time is limited. The feeling that his spontaneity state is weak may discourage the subject from the start and force him to stop after a short run.

Technique of Soliloquy

In the first type of soliloquy the asides and the dialogue operate within the private world of the subject. They are in different dimensions, but they belong to the same person; they belong to the same scene, which they both portray. The "open" part re-enacts the bodily and mental processes that had actually occurred in the original situation. The soliloquy part enacts the bodily and mental processes that were present at that time but were not expressed. It is an enlargement of the self through a psychodramatic technique, and these secret mental processes flow to the person to whom they should have been communicated originally. It is here that the therapeutic effect comes in.

A second type of soliloquy has been invented in which the official act and the soliloquy are on different levels. The official act

portrays a fictitious role and a fictitious situation; for instance, God in Heaven or Mephistopheles in Hell. The soliloquy act in the psychodrama will differ from the private asides in the legitimate theater. The soliloquy acts in psychodrama are private reactions of the patient and his partner. They portray the unspoken, private feelings that they may have in regard to themselves, to each other in their roles, to the task they are trying to produce, or to persons in the audience. Imagine John Barrymore and Eva Le Gallienne acting on the legitimate stage in the roles of Shakespeare's Romeo and Juliet, and imagine too that Barrymore and Le Gallienne are permitted to express in asides their private feelings about each other. *These soliloquies are not enlargements but resistances to a full development of the role.* It is here, therefore, that a therapeutic approach comes in.

A spontaneous subject who is entirely absorbed in the role is unable to soliloquize either in regard to himself or in regard to the role. It is with that part of his ego which is not swept into the role—has not been hypnotized by the role—that he can soliloquize. The weaker the role absorption by the ego, the more often can the ego soliloquize. If the ego cannot warm up to the role at all, we shall find the subject on the stage soliloquizing, making excuses for not getting into the role or suggesting different roles for himself.

The frequency of soliloquy is here a test of the intensity of the role. The more often the role is interrupted, the weaker will be its unity. Many times the patient is seen breaking up the flow of associations. The empathy that the role demands is not present. This is evident whether he soliloquizes or not. The closer these interruptions are to the end of the role the harder it is for the patient to throw himself back into it. If a role starts with sufficient intensity, the patient is protected against the effect that interruptions may have upon his performance. The interruptions may come either from within himself or from his partner in the act. These interruptions are called *resistances*.^{*} They can be introduced by the psychiatrist

^{*} Do not confuse this use of *resistances* with the psychoanalytic use of the word.

at will into the course of action in order to train the patient not to give up his empathetic role while acting, even though resistances emerge spontaneously either from within himself or from a partner.

The objective of therapy here is not so much analysis of the subject or his partner independently as a careful analysis of their interrelationships, with a special study of every fundamental "role" in which they act as partners. Parallel with the interpersonal analysis of the roles in which they act should go a methodical preparation of the roles that they need to act in the course of their "training." Indeed, it cannot be otherwise, since the analysis is fruitful only as the training proceeds. *The technique of improvisation is the royal route of spontaneity training, since it throws the patient into roles, situations, and worlds in which he has never lived before and in which he has instantly to produce a new role to meet the novel environment.* More than therapy is provided—the training and development of a new personality that may differ greatly from the one that was brought for treatment.

The Role of Spontaneity Training in Psychotherapy

To analyze a patient and, when this is finished, to leave him to his own devices are often not sufficient for adjustment and cure. Methods of training have been devised that develop incomplete personalities to less incomplete and more satisfactory states. The difficulty is to discover the precise point at which this technique can be applied most effectively. It has been found that *the most satisfactory point of treatment of an individual is the psychological level on which he is truly spontaneous.*

The level on which the patient is spontaneous may differ considerably from one function to another. It may be, for instance, on an immature level for one role and on a mature level for another role. Needless to say, to discover these levels, the momentary structure of each fundamental situation in which the patient operates has to be carefully analyzed. A technique of training does not come "out of the blue" but emerges in close contact with these momentary

structures and out of them. The level at which the patient is susceptible to influence and to training varies from individual to individual, often from situation to situation. A technique must be modified to meet the needs of each individual. The responsibility is great, because a technique of training applied on the *wrong* level can be wasted effort or harmful.

The process of exploration during psychodramatic work is already a tentative phase of training. Gradually, in accordance with the need of the patient, roles that he learns to embody are constructed and situations to which he learns to adjust are created. For all patients who suffer from interpersonal difficulties, the gradual and appropriate interpolation of resistances is effective.

Another method of training is based on the use of appropriate starters. They are important for patients who cannot easily warm up to a task or whose warming-up process leads to a distorted pattern. The catatonic patient illustrates the individual who cannot warm up to a task. The stutterer illustrates the individual who warms up, but to a distorted pattern.

The Warming-Up Technique

Spontaneous states are brought into existence by various starters. The subject puts his body and mind into motion, using body attitudes and mental images that lead him toward attainment of that state. This is called the *warming-up process*. The warming-up process can be stimulated by bodily starters (a complex physical process in which muscular contractions play a leading role), by mental starters (feelings and images in the subject that are often suggested by another person), and by psychochemical starters (artificial stimulation through alcohol, for example).

The therapeutic process in psychodrama cannot be understood without a full consideration of warming-up techniques. As is well known, in many exercises, such as running, swimming, or boxing, the ability of the athlete to warm up to the task easily and undisturbed has a great deal to do with his form and efficiency. The

"physiodrama" of professional athletes has been studied, and their spontaneous behavior during performance situations has been found to be similar to the warming-up process described here.

In spontaneity work and psychodrama the psychopathology of the warming-up process has, if possible, a still greater importance than it has in physical culture. Every role, in order to obtain proper performance, needs to focus and start off with a different set of muscles, which carry along many auxiliary systems during the exercise. Every time a different role is acted, for example, the role of the aggressor, the role of the listener, the role of the timid, the role of the cautious, the role of the self-observed, the role of the lover, and so on, a different set of muscles is specially accentuated and thrown into exercise. Many roles in order to be enacted require two or more *complementary* individuals, for example, husband-wife or parent-child.

Through the warming-up process numerous roles are brought into expression which the individual rarely or never lives through in his daily routine and which even in his night and day dreams are rarely and slightly touched. In his daily routine an individual may be limited to a small number of roles and situations, but the potentialities of his personality for roles is practically infinite. We live with only a small part of our personality range; most of it remains unused and undeveloped. During the course of psychodramatic treatment, however, a patient may live in hundreds of roles and situations and thus expand his life.

During experimentation with numerous subjects, it was discovered that *every warming-up process that covers a small range of the personality can be absorbed and for the time being undone by any warming-up process that has a wider range but includes these parts at the same time*. This principle has been seen at work so often that it can justifiably be considered a practical rule. It is on the basis of this observation that a significant therapeutic technique developed.

Tele and Transference

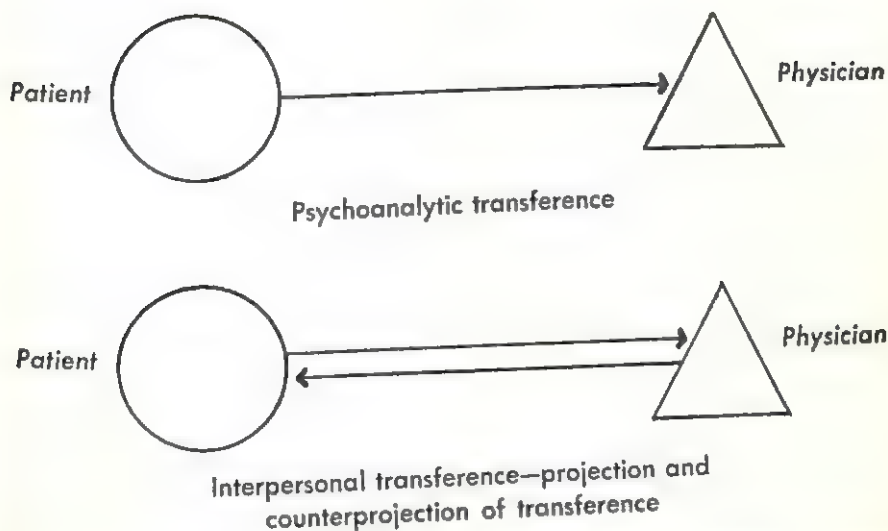
The following quotation from Sigmund Freud, the author of the transference concept, should help in distinguishing between transference and *tele* relationship:

A transference of feelings upon the personality of the physician . . . it was ready and prepared in the patient and it was transferred upon the physician at the occasion of the analytical treatment As far as his transference is positive, it clothes the physician with authority and it produces faith in his communication and interpretations His feelings do not originate in the present situation and they are not really deserved by the personality of the physician but they repeat what has happened to him once before in his life.

This transference concept developed gradually out of hypnotism and suggestion. Mesmer and the old-time hypnotists thought that some fluid flowed from the psychiatrist to the patient and put him into the hypnotic state. Later, when Bernheim showed that a patient can put himself into a hypnotic state through autosuggestion, the conclusion was that the mind of the patient was all that mattered. He is the hypnotist and the patient in one. Thus, the personality of the outside hypnotist or psychiatrist appeared negligible. Psychoanalysis studied the situation further and demonstrated that it is the patient who, in identifying the psychiatrist with certain fantasy products of his own, *projects* emotions into the psychiatrist. The psychoanalyst, cognizant of this mental process in the patient, makes it the basis of treatment.

Spontaneity and psychodramatic work have produced a still clearer and broader view of the physician-patient relationship. In the psychoanalytic situation there is only the one—the patient—who transfers, whether positive or negative. There is only one pole. The psychiatrist is considered as an objective agent (at least during the treatment), free from emotional implications of his own and merely present to analyze the material that the patient presents before him. But this only appears to be so, perhaps because only the patient is

CHART I
TWO CONCEPTIONS OF TRANSFERENCE



analyzed. The psychiatrist and physician, with his equipment and superior knowledge, has been put into the foreground, and his private personality and individual make-up, which underlie that role, have been neglected.

This can be seen in any regular office practice. The psychiatrist is more attracted to one patient than to another, and the success of his treatments is mysteriously uneven. He succeeds with a patient with whom another psychiatrist has failed and fails with a patient with whom another psychiatrist easily succeeds. Such casual observations are strongly reinforced in the course of psychodramatic work, for in the psychodrama all participants are parts of the analysis.

It has been observed during psychodramatic work that the psychiatrist, like the patient, suffers occasionally from transference toward the patient. Mental processes in his own mind that are related to the patient have a definite effect upon his conduct during the psychodramatic work. The suggestions that he makes to the patient, the role in which he acts, the analytical interpretation he gives, all

influence the outcome of the treatment. In other words, there is a partial return to the position of the hypnotizer and the preanalytic psychiatrist. Also, the psychiatrist projects fantasies of his own upon the patient. Transference therefore develops on both poles. *Not only tele but also transference is interpersonal*, and the psychiatrist is no exception to the rule. Analysis should be made from both ends of the line.

Psychoanalysts have been aware of this problem and have tried to free the prospective practitioner of psychoanalysis from his own personal difficulties through an educational analysis. Unfortunately, the process just described cannot entirely disappear even after such a preparation. The prospective practitioner may have become free from transference in regard to the specific psychiatrist who analyzed him, but that does not mean that he has become free from transference in regard to any new individual whom he may meet in the future. For that he would need the armor of a saint. His armor may crack any time a new patient marches in, and the kind of complexes the patient presents to him may make a great difference in his conduct. Every new patient produces a spontaneous relationship with the psychiatrist, and no educational analysis that has been carried out previously can preview and check all the emotional difficulties emerging on the spur of the moment.

In my opinion the self-analysis of the psychiatrist is not a sufficient check on this process. In the earliest days of psychodramatic work one of the first recommendations made was that the psychiatrist who participates in the procedure, as well as the patient, must be analyzed by *others* during the treatment.

A further study and analysis of a large group of normal and abnormal individuals showed that transference plays a definite but a *limited* part in interpersonal relations. Normal individuals show selective affinities for some persons, and some persons may show selective affinities for them in return. In every type of social situation—in love, in work, and in play situations—this preference of one individual for another is, in a large majority of cases at least, not due to a symbolic transference. Such preference has no neurotic motiva-

tions but is due to certain realities which this other person embodies and represents. The affinity need not be mutual, but it is important that the individual be attracted to a *reality* in this other person. The factor shaping the interpersonal relationship must be a new factor differing from the mechanism of transference, unless the meaning of this concept is stretched inappropriately beyond its original meaning.

A complex of feelings that draws one person to another and is aroused by the *real* attributes of the other person—individual or collective attributes—is called a *tele relationship*. The *tele* relationship is able to clarify that part in the psychiatrist which is mysterious. A psychiatrist may be relatively free from transference, but he is never free from the *tele* process. It may be that he is naturally attracted to or naturally repelled by or indifferent to certain patients because of their actual individual attributes. The same is true of the patients. Thus, it may be because of the *tele* factor that a psychiatrist is successful with some patients and unsuccessful with others. Therefore the second recommendation is that great care must be used in assigning the patient to a psychiatrist or attendant, since not every psychiatrist will be suitable for every patient and there are definite *tele* limitations.

The social atom of an individual is thought of as consisting of crisscross affinities between him and a number of individuals and things on numerous levels of preference. The social environment in which the individual functions may be, and most often is, in utter discord with his socio-atomic structure. The social atom is used as a guide for techniques of person-to-person and person-to-thing assignment. As the individual is moved nearer to certain individuals and things, a deep experience takes place in the participating subjects. It is at that point that the *tele* becomes therapeutic. The larger the number of participants, the more demonstrative is the activity. The experience is in essence the same whether twenty-eight girls of the Hudson School Community find at their table, actually sitting near them at supper, the girls they have invited or whether 135 settlers moving into a new community find mutual friends as their neighbors. "It is like starting a new life"—"I am so happy now"—and

similar utterances are heard, indicating feelings that the verbal symbol cannot adequately represent in the process. The fact that an affinity has an extra-verbal structure does not necessarily mean that they are remnants from an infantile level of development. It means merely that there are numerous feeling complexes for which language is a poor medium.

When a patient is attracted to a psychiatrist, two processes can take place in the patient. One process is the development of fantasies (unconscious) which he projects upon the psychiatrist, surrounding him with a certain glamour. At the same time, another process takes place in him: that part of his ego which is not carried away by autosuggestion feels itself into the physician. It sizes up the man across the desk and estimates intuitively what kind of man he is. These feelings into the actualities of this man, physical, mental, or otherwise, based partly on information, are *tele* relations. If the man across the desk, for instance, is a wise and kind man, a strong character and the authority in his profession that the patient feels him to be, then this appreciation of him is not transference but an insight gained through the *tele* process. It is an insight into the actual make-up of the personality of the psychiatrist.

The point can be pursued even further. If, during the first meeting with the patient, the psychiatrist *has* the feeling that he is superior to the patient, and if the patient experiences this from the gestures the physician makes and from his manner of speaking, then the patient is attracted not to a fictitious but to a real psychological process going on in the physician. Therefore, what at first sight may have appeared to be a transference on the part of the patient is a true *tele* projection. The patient may have subjective reasons to believe that the doctor is entitled to that almighty feeling that he has about himself, and that the better the man, the better is the chance to be cured by him.

A similar process happens between two lovers. If the girl projects into her lover the idea that he is a hero or that he has an excellent mind, this may not be at all a fictitious construction but the experience of the role he plays toward her, the role of the great lover, of

the man who is going to do great things. She is attracted to the realities of the momentary structure within him, the man before her. Even though at the start she had images of him that were unfounded, the better acquainted with him she becomes the more the transference vanishes and gives way to the *tele* process. The *tele* process is not necessarily less fantastic or less romantic than transference. The romance is based on interpersonal realities. The *tele* relation, to the configuration of his mind, the rhythm of his body, the color of his hair and eyes, his social positions, and so on, which she has had from the beginning, breaks forth more and more and establishes the real bond between the two. Transference is a strictly subjective process within the patient or any one individual; whereas the *tele* process is an *objective* system of interpersonal relations. Besides the *s* (spontaneity) factor, it is the *tele* factor, not transference, that acts in the cure. Transference is the factor that hinders the cure.

It appears that there are two principal reasons why the transference concept is used uncritically. (1) The momentary psychological structure of an individual as it emerges spontaneously and grows in the course of the treatment is not considered sufficiently by psychoanalysts. They are too much fascinated by the idea that the feeling the patient has for the psychiatrist is an emotional hangover of past memories (for instance, of an Oedipus complex). (2) The approach of psychoanalysis was fully justified when it entered the field about four decades ago, but the status of psychology as a science has changed since then. As long as psychotherapy was carried out for a single person, it was easily possible to take transference at its face value as an unobjective projection of a patient upon his doctor. But as soon as interpersonal therapy began to study the spontaneous interactions of many persons toward one another, it became clearer from step to step that the transference process itself was in many respects an expression of dream work, not of the patient this time, but of the psychiatrist.

The tele relation can be considered the general interpersonal process of which transference is a special psychopathological outgrowth. In consequence, underlying every transference process pro-

jected by a patient are also complex *tele* relationships. Many factors that are uncritically assigned to transference are true *tele* projections. As long as transference is the only crux of psychotherapeutic treatment, the personality make-up of the psychiatrist does not matter. It is sufficient if he is well analyzed and highly skilled in his specialty. But since the therapeutic *tele* process has to be recognized as a new and important crux for treatment, the situation has changed. The other personality has become extremely important and with it, in varying degree, all other personalities within the social atom of the patient. The *tele* structure therefore suggests a proper assignment of a person to another person or to a group to obtain the greatest therapeutic advantage. The techniques of the auxiliary ego, the techniques of assignment, and the psychodrama open up new avenues of psychotherapy, especially for the infant, the child, the adolescent, the feeble-minded individual, the manic-depressive, and the schizophrenic.

Psychodrama fo an Adolescent

Characters Participating in the Psychodrama

J. L. Moreno, the director

Bill, the Adolescent

Dr. and Mrs. Masterson, Bill's parents

Mr. Frank, the social worker

Auxiliary Egos (sitting in the audience): two female egos, two male egos, two recorders.

A minimum of auxiliary egos is necessary for production; one representing *man*, one representing *woman*; one representing any other male roles; one, any other female roles; and both portraying also any imaginary roles required. This makes four auxiliary egos; they are frequently reducible to two, one male and one female. Their reliability and consistency in interaction is measured.

The sessions with Bill take place once a week, on Saturday afternoon.

Place

The Therapeutic Theatre, Beacon, N.Y.

Time

In the course of 1939.

THE PROBLEM

Mr. Frank, social worker, steps upon the stage and speaks to the audience, director, and auxiliary egos, prior to Bill's entry into the theatre:

Bill is fourteen and a half years old, with an unruly, unkempt shock of blue-black hair. He has been at a reform school near Montrose, New York, for four weeks. We have had a good opportunity to observe him there. He was sent to us by the Child Guidance Bureau for observation, diagnosis, and, they hope, treatment. The Bureau describes his father as an independent physician and his family as well-to-do. Bill's disturbances have become more acute in the past two years, but they started with the birth of his younger brother eight years ago. He has told us how he went to the World's Fair with his mother, who was pregnant at the time. He was embarrassed more than was necessary. His record in Brooklyn, where he lives, shows that he has been a truant from school. He takes food from the icebox and will not eat regular meals. He goes to bed late and refuses to get up at the regular time in the morning. His parents have tried sending him to military schools and camps. He has run away from a number of them and turned up at home in from one to three days. He was brought to the notice of the Child Guidance Bureau. They were to take measures, and it was they who recommended that he be sent to us. Two doctors have made psychiatric comments. One said that Bill had psychotic ideas but made no diagnosis. The other said that this was a normal phase and that Bill could return to school. There was some question in the minds of the doctors of the Child Guidance Bureau that these physicians might be reluctant to diagnose because they were colleagues of the father. They suggest that an outside diagnosis be made.

Since his admission to the school, Mrs. Rice, the principal, has had

him under careful observation. He seemed morose and ran away to his home. His parents telephoned, and he was brought back. He was reluctant to do his duties in the cottage. When he started, he seemed hesitant and would stop his work. After long pauses, he would finally bring himself back to the job. Two days ago he was told to take a carpet outside and beat it. He walked into the living room and stared at the carpet for fifteen minutes. Then he took it outside and after a long pause took up the beater. The housemother of his cottage noticed that there were things missing from the ice box. She is certain that Bill is to blame. Since he has been in the cottage, there have been a number of sex incidents. He is said to masturbate excessively, and a few days after he was received he refused to get out of bed. He had no pajamas on and exhibited himself and his genitals in the nude to the housemother. She paid no attention. A couple of days later the same thing occurred. He likes to sleep in the nude and does not want to get dressed because he prefers to stay naked. Later he began masturbating before the housemother and the boys. She scolded him but did not make an issue of the episode.

Certain incidents of *self-made psychodrama* were told to me and make me think that Bill may profit from systematic psychodramatic therapy. The other day the housemother heard a noise upstairs, went up and found Bill marching up and down between the beds, giving military commands and executing them himself. Suddenly he stopped, called to attention, and said, "Bill, here is a cup for distinguished service." He then changed into the role of commander and continued the maneuvers and military formations. When I heard this, I talked with his parents, and they agreed to bring him here.

FIRST PSYCHODRAMATIC SESSION

Moreno and Bill are sitting on the middle level of the psychodrama stage, often referred to as the interview level. Moreno is addressing Bill.

MORENO: Have you ever acted before, Bill?

BILL: Yeah.

MORENO: What kind of things have you acted?

BILL: Oh, in a few—I forget. I like dramatics.

MORENO: What are you going to do in life? What are your plans?

BILL: I like science. I'm going to be a doctor, like my father.

MORENO: What kind of specialty has your father, and where does he practice?

BILL: A general practice in Brooklyn.

MORENO: What kind of patients has he?

BILL: Oh, different. Removing arms and feet.

MORENO: Is he a surgeon?

BILL: He does surgery.

MORENO: Have you ever seen an operation?

BILL: He wouldn't let me see an operation.

MORENO: What kind of hospital is he associated with?

BILL: Catholic hospital.

MORENO: I suppose you've gone to school? How far have you gotten? You're in high school I suppose?

BILL: Yes, high school. The second half.

MORENO: Do you like medicine?

BILL: Yes, but it takes so many years until you're out of college and through medical school. I figure you are twenty-eight.

MORENO: But some do it faster, don't they?

BILL: Yes, but I'm not a genius.

MORENO: How old is your father? And how old was he when he became an M.D.?

BILL: Oh, he graduated from school young. He was young when he got his degree, twenty-five.

MORENO: How long have you known Frank? (*The social worker who brings Bill to the Theatre and is assigned to Bill's case.*)

BILL: I met him when I came to Montrose.

MORENO: Are you happy there? Why are you at Montrose?

BILL: For playing hooky at private school.

MORENO: What private schools did you go to?

BILL: Oh, a couple. Different private schools.

MORENO: What was the name of one of the schools?

BILL: Durhold Military School. That's the one I liked best.

MORENO: Why didn't you stay there?

BILL: I thought I'd go to another, but I found out that they are not all like Durhold. If I make good at Montrose, I can go back there.

MORENO: How long were you there?

BILL: Two months.

MORENO: Why did you run away?

BILL: I ran away because I wanted to go back to public school. Before, I didn't like public school. That's why I played hooky.

MORENO: Do you like playing hooky?

BILL: No, but I played hooky.

MORENO: What happened?

BILL: Oh, some reasons came up.

MORENO: What reasons?

BILL: I slept all the time. Then I was afraid to go back and face the consequences with the teachers.

MORENO: Were they very strict?

BILL: Well, they didn't treat you like this and that.

MORENO: Would you like to stay home?

BILL: Well, yes.

MORENO: Where would you like to go now?

BILL: You mean, what would I like to do?

MORENO: Yes. Imagine it's all up to you.

BILL: I'd like to get settled. I didn't get settled in Montrose. When everything is all right and I can work in peace, then I can hurry up and get finished and go to college. Then, after college, medical school.

MORENO: Are you happy at Montrose?

BILL: They put me into a cottage with boys older than myself. It didn't agree with me. They bothered me.

MORENO: Why did you run away from school? Why did you go to a private, military school?

BILL: It was my idea. I thought I'd like it.

MORENO: When did you go there?

BILL: It was last October.

MORENO: What did your father say?

BILL: He said it was very expensive. "Cost a lot of money."

MORENO: If you had difficulties there, why didn't you go to your father about it?

BILL: He's not a psychologist. He doesn't like to make this hocus-pocus.

MORENO: So you didn't like it at military school?

BILL: No, it was there I ran away—I saw a car on the road. I stepped in and drove away.

MORENO: Whose car was it?

BILL: I don't know.

MORENO: Have you run away many times?

BILL: Quite a few times.

MORENO: Did you run away with someone, or did you go alone?

BILL: Always alone. I never can do it with another fellow. That makes me nervous. I like to be on my own. It's safer.

MORENO: Why did you run away?

BILL: I like to travel, I guess. I like to see the world.

MORENO: But it's kind of expensive, isn't it?

BILL: Yes. When I'm older, I figure I'll see the world. Now I'll stay down to brass tacks.

MORENO: You want to learn something, is that it?

BILL: I want to *be* something.

MORENO: I understand you have only one brother. You like him?

BILL: He's excellent. He's very smart.

MORENO: How old is he?

BILL: He's six and a half.

MORENO: Don't your father and mother miss you?

BILL: I guess so. They write pretty nearly every day.

MORENO: How did they happen to catch you home?

BILL: I slept through, and when I woke up they had me. I expected it, and I was going to explain.

MORENO: Don't you think you make it kind of complicated? Why didn't you talk it over with Frank?

BILL: I didn't want to bother Frank. Besides, I wanted to see Audrey and get some things—pipes and tobacco.

MORENO: Why didn't you say these things to Frank?

BILL: I wanted to speak privately to Audrey.

MORENO: What did you tell her?

BILL: I told her a few things, private things.

MORENO: What did she say when you told her?

BILL: She said I ought to do something about it. She said she didn't want a jailbird for a boyfriend. She didn't want to see my name on record and have my name ruined.

MORENO: What do you think about it?

BILL: I think she's right. That's why I want to be in a good cottage.

MORENO: Did you tell her everything?

BILL: Yes. I realize that I have to do it myself and do it without help.

MORENO: Were you ever in jail before?

BILL: No, but I was in an orphan home before I went to see the judge. I was afraid to see the judge.

MORENO: Was this after you were in military school?

BILL: Yes.

MORENO: Why did you go to jail?

BILL: I don't know. It was a frightful day. I felt awful when I saw the judge.

MORENO: Joe here has had a lot of experience with courts and judges. I'd like to have you act out the scene that took place with the judge, with him, just as it happened. If you'll go up on the stage with him, you can tell him what occurred and act it out together.

ACT I

Bill and Joe go backstage for preparation and then come back on stage. They arrange the furniture, table, and so on, to simulate the judge's chambers. Bill assumes the role of defendant and remains standing throughout.

JUDGE (Joe): How do you do? What's your name?

BILL (out of role): He didn't ask me that. He could see it on the record.

JUDGE: Now, I understand you have run away from military school.

BILL: (Nods; looks depressed.)

JUDGE: I see also that you stole money from a cash register.

BILL: (Nods again; lowers his head.)

JUDGE: Then you stole a driver's license and plotted to steal an automobile from the Broadway Garage.

BILL: (Nods again despondently.)

JUDGE: Well, it's clear that I can't send you back to military school. I want you to try to make a go of it in a reform school.

BILL (out of role): He said something like they were going to send me to Montrose for a "rest." He said that if I want to go back to military school, I gotta make good at Montrose.

JUDGE (*out of role*): Well, let's try it over again. (*After a little more detailed preparation they try again. The judge repeats much of the above.*)

JUDGE: No, I can't send you back to military school. I'm going to send you to Montrose for a rest. We'll see if you make good there before we can let you return to military school. What do you say to that?

BILL: Yes, Your Honor. I'm sorry for what I did.

JUDGE: Have you anything else to say?

BILL: No.

JUDGE: Why did you run away? Why did you do all those things?

BILL (*out of role*): He didn't say that. I said to the judge: (*Back in the role*) Let me go home, Your Honor. I want to go to school there.

JUDGE: You want to live at home and go to school there?

BILL: Yes. I don't like military school.

JUDGE: Then why did you want to go to military school in the first place?

BILL: I wanted to see what it was like.

JUDGE (*looking over some papers on his desk*): I see that your record in public, private, and military school shows that you play truant; and in military school you steal military uniforms. Is that right?

BILL (*out of role, dejectedly*): Yes. That's why they sent me to Montrose.

JUDGE: Now, I want you to promise that you won't run away from Montrose, that you'll make good there.

BILL: Yes, Your Honor.

JUDGE: That's fine.

(*End of scene*)

MORENO: Is that how it was? Is that how you acted before the judge?

BILL: It was more real. I was afraid.

MORENO: How did the judge act? Show me.

BILL (*in the role of the judge, sits down in the judge's high chair and from time to time steps down and takes his own part. He comments on the actions as he goes along.*)

JUDGE (*Bill*): The people from the Child Guidance Agency have picked out a nice school for you to go to in Montrose. If you make good after a trial period there, you can go back to military school.

BILL (*self*): Yes, Your Honor.

JUDGE (Bill): If you don't make good there, you will be brought back to see me! (*Voice becomes very stern.*)

BILL (*as self, very depressed*): Yes, Your Honor.
(*End of Act I*)

MORENO: How did you feel?

BILL: I was stunned. I didn't know what to say.

MORENO: What was the name of the judge?

BILL: Judge Lawson. He's a very nice man. His hair was all white, he had a deep voice, like this. He said (*imitates in deep voice*), "Bill, it's up to you."

MORENO: Is that the only time you saw him?

BILL: Yes.

MORENO: How long ago was that?

BILL: October.

MORENO: Let's see—you got home Monday?

BILL: No, I got home Tuesday. I came back today.

MORENO: Now, as I remember it, you said that you had altogether one dollar.

BILL: Well, maybe I had a little more.

MORENO: How much would you say you had altogether? Did you borrow some money from Audrey?

BILL: No. I wouldn't take money from a girlfriend. I wouldn't think of such a thing!

MORENO: Didn't she offer you anything?

BILL: She offered me candy and hospitality.

MORENO: Did you go to her home?

BILL: Yes. I told her why I didn't write.

MORENO: She's a good girl, is she? Does she go out with other boys?

BILL: No, she didn't.

MORENO: At military school, did you have any difficulties?

BILL: Well, when I did, a couple of times, there was challenging and boxing.

MORENO: How was that?

BILL: In military school you challenge instead of fighting. A guy challenged me to fence. I lost, naturally. Then I challenged to boxing and I won twice, but first I lost twice.

MORENO: The same boy?

BILL: No. I had other enemies. Not exactly *enemies*. I had lots of friends, too. About three quarters liked me.

MORENO: Frank, I understand you talked with Bill's mother?

FRANK: Yes, I met Bill's mother and talked with her this morning.

BILL: I saw him stepping out of the car, through the window.

MORENO: I should like to have Miss Wright take the part of Bill's mother. Bill, you be your father, and Frank, you are yourself. Show us what occurred. Bill and Frank, you explain to Miss Wright what took place. First I want to see Bill's mother and father together, giving us a picture of their life at home. Then you, Frank, come in and show how you met Bill's mother.

ACT II

Bill, Wright, and Frank go backstage for preparation and reappear after a minute or two. Bill plays his father's voice offstage, then himself, and later sits in the audience, watching Frank and his mother, acted by Wright.

FATHER'S VOICE (Bill) (*From downstairs, where the office is, to Bill's mother angrily*): Stella, for the Lord's sake, stop crying. It drives me crazy. I can't work here!

MOTHER (Wright): I'm so desperate about Bill. (*Cries.*) You just don't care, you have no heart. My mother says . . . (*Cries again.*)

FATHER (Bill): Your mother . . . why do you always have to bring her into everything? (*Slams door.*)
(*End of scene*)

BILL (*explaining the following scene*): Now I'm myself. This is later in the day. I'm looking out of the window and see Mr. Frank coming out of a car. I wonder what Mr. Frank is coming here for? Mother, Mr. Frank is coming.

(FRANK rings doorbell.)

MOTHER: How do you do, Mr. Frank? I'm glad to meet you.

FRANK: How are you, Mrs. Masterson? Hello, Bill.

MOTHER: Bill has told me about you.

BILL (*to Frank*): You're coming for me, eh?

FRANK: I'm sorry, Bill, but that's my job.

Bill looks depressed, wanders aimlessly out of the room.

FRANK: This is what happened. First he was there, but later on Bill left. (To Bill's mother) How did Bill get along at home, Mrs. Masterson?

MOTHER: He had his meals regularly. He was no trouble. He's much improved.

FRANK: That's fine. I'm so glad to hear it.

MOTHER (nervously): He took some money out of his father's pocket. That was the only thing he did wrong. (Cries.) Do you want to see his father?

FRANK: No. I just spoke to him.

MOTHER: My husband says that Bill is a sick boy and should be seen by a psychiatrist.

FRANK: That is what I came to see you about. I have discussed this with Dr. Masterson, and I am taking Bill over to see a friend of mine, Dr. Moreno. He may suggest a plan of treatment.

MOTHER: Oh, I would appreciate that. If Dr. Moreno can help Bill, I should be very grateful.

FRANK: Well, that's what we'll do then.

MOTHER: I want to thank you for everything you're doing for my boy.

(End of Act II)

MORENO: This taking money out of your father's pocket, is this true, Bill?

BILL: Yes. I took a quarter.

FRANK: I understood that it was about two dollars.

BILL: No. I took a quarter, or maybe thirty-five cents. A few pieces of silver.

MORENO: How much did you say, altogether?

BILL: A quarter, or thirty-five. I'll pay it back—I was going to.

MORENO: Why didn't you tell me before?

BILL: I didn't want to tell. It was a small thing and I was going to pay it back.

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ACT III

BILL: O.K. (Walks around the stage, warming up, describing the scene.) All the boys are asleep, the moon shines through the window.

I am in bed next to the door. I suddenly wake up from a dream and look around.

Moreno instructs Joe to take the part of Bill's double. He explains to Bill.

MORENO: Here is your double, another Bill, yourself, acting exactly the same way you do. He is in bed next to you and suddenly awakes from a dream.

BILL I: Who are you?

BILL II (Joe): I am Bill, too.

BILL I: I had a strange dream.

BILL II: So did I, very strange.

BILL I: It was like this. (*Starts to get up.*)

BILL II: I was out of bed. (*Gets up too. Both do the same thing,*

Bill II copying the motions of Bill I.)

BILL I: I notice that you're naked.

BILL II: You're naked too, didn't you know?

BILL I: I like to sleep in the nude.

BILL II: My father does, too.

BILL I: I don't like to wear pajamas, but I wear my underwear. I may have walked around in my underwear.

BILL II: I may have gone around naked once in a while, but only in the reception cottage. Then I like to do exercises.

BILL I: It is only in bed that I am without anything on.

BILL II: That's right, only in bed, except when it's hot.

BILL I: My father sleeps in the nude when he is hot. I mean when the weather is hot, not when he is substantially hot.

BILL II: I feel good without clothes.

BILL I: Yes. Maybe I was stretching out, but I didn't think of doing anything like that.

BILL II: Like what?

BILL I: You know what I mean. Jerking off.

BILL II: I did it once.

BILL I: Yes, just to see how it was done. My friends had told me about it. I would never think of doing such a thing in a strange place!

BILL II: I never did it at all in Montrose.

BILL I: I admit it seems a screwy idea to sleep nude when three quarters of the fellows don't do it.

BILL II: Years ago the Romans wore clothes made of sheets. At least, they looked like sheets.

BILL I: Well, I guess you got to do what everybody else does. The Romans thought nothing of undressing right out in the square, and then they had steam baths there.

BILL II: Those times were different.

BILL I: Nowadays they have a change of society, as you call it. I don't like our society, how people are today. The cottage mother reported on me.

BILL II: I was in bed with no clothes on. I was afraid to get out of bed.

BILL I: Yes, and she stood there. She told me to get up, but I couldn't. Then she waited and looked at me in a mean way, but I couldn't get out. I had nothing on, I told her.

BILL II: I didn't know what to do and how to act.

BILL I: Suddenly she pulled down the covers. When she saw I hadn't any clothes on, she put them up again. I was in a fix. It was the first time I was ever ashamed so much.

BILL II: I always get into trouble. This is not the only thing.

BILL I: Yes, I know. There was also the report that some fruit was missing.

BILL II: Oh, yeah!

BILL I: I thought I might as well have some fruit once in a while, when I was hungry.

BILL II: I don't see why I should do that.

BILL I: I don't see, either. I get enough to eat.

BILL II: I have a good appetite.

BILL I: I get more than enough.

BILL I and BILL II (*together*): Well, I'm ashamed to ask.

BILL I: That's what I am. I thought it would be better if they didn't find out, but they did.

BILL I: The other day when I ran away, they said some money disappeared.

BILL II: It was blamed on me.

BILL I: Funny thing, when I came back the money returned.

BILL II: I had the idea someone tried a trick.

BILL I: But why should I steal my own money? Half of it was mine.

BILL II: Somebody must have stolen it.

BILL I: There is somebody—I wouldn't put it past him! I mean Eddy.

BILL II: But I'm not sure.

BILL I: I know it's him. He always asks me things which are private—about having a brother or whether it will be a girl. I was hoping for a boy—I prayed it would be a boy.

BILL II: I wonder if my mother wanted another boy?

BILL I: My mother wanted a girl—my father didn't know what he wanted. (*They open the door; both are walking out into the field; it is full moon.*)

BILL II: See the moon?

BILL I: I used to pray to the moon. I said, "Mom, give me a brother."

BILL II: The moon looks so peculiar tonight.

BILL I: The other night when my brother was born, it was shining full blast. I thought maybe a miracle had happened. Such things happen. And then my grandfather died one month before my baby brother was born.

BILL II: His death had something to do with it—that it was a boy.

BILL I: Well, I thought my baby brother may have something of my grandfather. I loved my grandfather.

BILL II: And so I prayed to the moon for a boy brother—and I got one!

BILL I: I didn't pray to the moon—I prayed to God. You can't pray to the moon!

BILL II: When I walk alone at night, I see funny things.

BILL I: When you walk and you look into blind space, into blank air, you see colors; you have to. I read someplace in a book that if you look at white things you see different things because you're human.

BILL II: Often, in the moonlight, I get frightened.

BILL I: Yes, I'm frightened that something might happen to me.

BILL II: That people might do something to me.

BILL I: That my mother wants to change me into a girl. (*Nervously.*)

Look at the sky.

BILL II: The moon looks so peculiar tonight.

BILL I (*as if praying*): Don't change me into a woman, let me be a man. I do hope my mother can be stopped.

BILL II: I'm sorry for her. She has no luck. She always gets boys. One after another. But I don't think that my mother really wants to change me into a girl.

BILL I (*pensively*): She could have done it *before* I was born, but now it is too late.

BILL II: It sure is. No mother can do it after the baby is born. Then he is someone by himself.

BILL I: Well, once I did have the idea. I read it in a book—where a man was changed into a girl. And then my penis hurt; that was done naturally, the changing; I was thirteen, I was a man; my testicles hurt, too, and I had to wear a jockey strap.

BILL II: I get jittery when I think about such things.

BILL I: Yes, and when I run I have a pain in my side. I am jittery all the time.

BILL II: I can't sleep when it's hot.

BILL I: I read in the newspaper how a doctor in Austria turned someone into a girl; then, in a theatre two years ago, a magician changed a boy into a girl. It worried me. I am still worried that I will be turned into a girl. If I am, it will be just too bad. But it will be done naturally. You may say that this is a goofy idea, but it may still happen. If I knew the reason I might feel better about it.

BILL II: I'd sure like to know how such things happen.

BILL I (*to Moreno*): That's what happened to me. That's how I felt. There are all kinds of thing I think about, life and other things.

(*End of Act III*)

MORENO: Do you feel well now?

BILL: Sure, I always feel well. At times I have headaches.

MORENO: Why is that?

BILL: Because of my eyes. I'm far-sighted. I've been wearing glasses for a long time.

MORENO: When did you go to the optometrist last?

BILL: These are just new glasses. I got them in October. When there are bright lights my eyes hurt.

MORENO: Now, Bill, what do you want to study?

BILL: I want to study science. I wanted to be an inventor.

MORENO: What kind of things did you want to invent?

BILL: All kinds of things.

MORENO: Why didn't you stick to it?

BILL: You have to take such hard subjects—like chemistry and physics. You have to be an Einstein. I'm not like Einstein.

MORENO: Do your testicles still hurt? For instance, when you play ball?

BILL: Yes, and sometimes my side hurts when I run and when I have nerves. My nerves are very bad. That was when I had my tonsil operation.

MORENO: What do you mean, your nerves are bad?

BILL: When I run I have a pain in my side. I'm jittery all the time.

MORENO: Do you sleep well?

BILL: I sleep all right. The only thing is, I need lots of air. Especially when it's cold. I can't sleep when it's hot.

MORENO: Did you think you would be changed into a girl because of your penis?

BILL: I heard about a case.

MORENO: Where did you hear about it? You said you read it somewhere.

BILL: Yes. It was in Austria. There was the story about two women who loved each other. I thought they must be out of their senses. Then it said a doctor was going to make a man out of one of them.

MORENO: I don't think you have to be afraid of what you read in the papers. They put a lot of things in papers. They are not always true, you know.

BILL: That's right. There are so many stories. Then once I went to a burlesque show and they talked so much about the sexes and all that.

MORENO: What do you like to think about, Bill, when you are alone?

BILL: I like to think about the future. After I'm gone, what will be here in a hundred years. I like to think about the past, present, and the future.

MORENO: What do you think will be happening in a hundred years?

BILL: I won't be here. I won't hear it, I know that.

MORENO: You like to think a lot, don't you?

BILL: Oh, yeah. I like to think about science.

MORENO: Have you any friend who is interested in science?

BILL: Only me.

MORENO: Is your father interested in science?

BILL: Yes, once in a while he tells me some interesting things. I like it but I don't want to devote my whole life to it. If I could be a doctor, or a surgeon, then I could spend my spare time being a scientist. I'd like

to be a scientist-doctor. You don't have to believe everything you read in the newspapers.

MORENO: If you are a scientist-doctor nobody can change you into a girl, eh?

BILL: Yeah. That's why I want to be a doctor myself! But I would like to improve my vocabulary. Right now it's going to the dogs.

MORENO: What's the trouble with your vocabulary?

BILL: Sometimes I can't find the right word. I seem to have lost my vocabulary. Now I know that in the military school I wasted my time and energy.

MORENO: Now, Bill, what do you think about the situation abroad?

BILL: Well, you would call it slaughter, real slaughter going on. But I think America should stay out of the war. But if there is a war, I would be glad to go. As if they would need a small thing like me! It looks to me as if war doesn't pay. It is just a waste of a generation. And then in the film the other day I saw some dead people in China. And then they showed the guillotine in France and in Germany. It was horrible. Just slaughter all over the place.

MORENO: Well, Bill, I thank you. It was a fine session. But our time is up. We have to close.

DISCUSSION

This is the first of a series of twelve sessions, which take place at weekly intervals. Treatment ended with social rehabilitation of Bill. He entered a military school, was later admitted to college, served honorably in the United States Army, and is now on the way to becoming a doctor of medicine.

The first session in a "psychodrama development" is most difficult to handle because of its strategic importance; a small tactical error of the psychodramatic director and the whole treatment program may be blocked. The first session often looks different from the later ones. In it the problem of the subject has to be brought into relief. In this particular first session the opening interview is extremely prolonged because of the subject's suspicion and distrust of therapists in general. The length and content of a psychodramatic

interview is a matter of directorial strategy. It has two aims: to put the client at ease and make him ready for action and to discover the clue for a problem and situation to which he is spontaneously warmed up at the time. The interview may be relatively long or short, depending upon when the clue for such a situation is found. What matters are the intensity of the warming-up process signified by the subject and the significance of the specific problem for him. To begin with, it does not matter whether the problem refers to a past, present, or future event. What matters is whether the situation *clicks* with the spontaneous level of the patient.

Because of limitations of space, the "running commentary" of the director and the "process analysis" of the session have to be stopped at this point. For the full account, see "Psychodrama of an Adolescent," *Psychodrama*, Vol. II.

The range of roles that Bill portrays in this session are Judge, Father (his own), Double (his own). He is the central character in three scenes which show the following interaction of roles: (a) self-judge; (b) self-father-mother-social worker; (c) self-double. The question can be raised whether it would not have been possible to shorten the interview and move Bill into action *before* the judge and court complex came to the fore. Two important experiences were touched on previous to this: running away and the girl. These were important clues in themselves, but it was Bill who decided whether he was ready for the clues or not. It was the way he acted that made the director cautious and influenced him to decide against the choice of these experiences. Bill still appeared unwilling to cooperate in the drama wholeheartedly; his head was down, and he was glancing sideways at the audience with an air of suspicion; he made grimaces expressing disdain, sucked his fingers, and talked in a low voice. These gestures of fear, protest, and withdrawal distorted by hostility against the world came to an end when he described how he was sentenced to the reformatory. At this point he was entirely absorbed by the experience, and quickly the director seized the opportunity and suggested action.

The sequence of scenes has to develop as naturally as the weav-

ing of the opening interview; the going-to-jail scene moved naturally into the next scene, that of being caught by an officer and brought back to the reform school. The third scene came from a surprise clue. It came from the casual remark of Bill that he had had a dream the previous night. It is for such deeper clues that the director has to wait patiently. The director here rapidly connected information received from the social worker about Bill's sexual behavior during the night. Such connections are made by the director in a flash, on the spur of the moment. They cannot be planned in advance, because it all depends upon the readiness of the subject for the clues. The best clues may not work if he is not yet ready for them, and quite bold clues might unpredictably work. Diagnostic preparation is wise; the psychodramatist should know as much as possible about the case. But often diagnosis and treatment have to go hand in hand. A diagnostic clue is discerned on the spot and immediately used for therapeutic aims.*

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Summary

Daniel E. Sheer

Associate Professor of Psychology and Director of the Psychological Laboratories at the University of Houston, Dr. Sheer is a graduate of Johns Hopkins University and of the University of Michigan in clinical and experimental psychology, having received the Ph.D. degree from the latter in 1951. He has been Research Associate at Columbia University and has received training at the New York State Psychiatric Institute, as well as at various Veterans' Administration clinics.

Such a combination of research orientation and clinical experience makes possible a much needed approach to the problem of psychotherapy at its present stage of development. As his contribution to this book, Dr. Sheer has undertaken the immense task of integrating the various psychotherapeutic theories and techniques, as they have been presented by the six other authors, through an extensive examination of these approaches in terms of both clinical and experimental frames of reference. He has, moreover, evaluated the level, scope, and applicability of the six methods, bringing to bear a certain degree of objectivity, together with an inquiring manner of investigation, in order to determine the extent of the contributions of research toward a further understanding of the various theories and techniques that underlie the different approaches and to determine the direction that comparable research needs to take in the future.

In addition, Dr. Sheer has attempted to view the different psychotherapeutic methods in terms that are applicable to all by reconstructing the concepts upon which each of the approaches is based and by incorporating various fields and areas of psychology as they pertain to psychotherapy. Finally, he has emphasized some of the common threads that interrelate the forms of therapy presented in this volume.

Summary

THIS BOOK has presented only a limited sample of the numerous possible approaches to psychotherapy. In the Introduction the general area of psychotherapy and the different classifications—each with some merit—have been described. We shall therefore restrict ourselves here to a comparative evaluation and some integration, tentative though it may be, of the six approaches already detailed.

It would serve no useful purpose to rephrase in diluted form the different views that have been ably presented by their respective proponents. Rather, with the selective sampling (and it must necessarily be selective) of various research data, concepts, and theories, a more comprehensive framework will be presented within which one may profitably compare the different approaches.

In the first section of this summary we shall examine the different theories and techniques in terms of their interrelationships. The various approaches may be differentiated on the basis of theoretical assumptions, therapeutic objectives, and specific methods and techniques. It should prove fruitful to examine the basic propositions underlying these differences, especially since they affect the level, scope, and applicability of each approach.

In the second section, we shall consider research studies which may provide objective data on the efficacy of the various therapeutic approaches. These investigations are, in general, designed to evaluate the effectiveness of certain therapies or to test the validity of specific hypotheses concerned with what goes on in the therapeutic process. They may utilize various external criteria of successful therapy, such

as psychological testing, behavior ratings, judgments, and life histories. They may also develop measures based on internal criteria; that is, on changes during the therapy process itself.

Finally, in the last section we shall make a tentative proposal for examining the various approaches within a common framework. There have been many attempts to integrate different therapeutic orientations within a consistent theoretical system. In recent years, both active therapists and those interested primarily in theory have expended considerable effort toward finding some areas of agreement.

One major difficulty arises from the use of divergent language systems at different levels of abstraction to express similar ideas and to develop overlapping concepts. By restructuring the concepts of each approach within broad categories, areas of convergence should emerge. The selection and organization of these categories must necessarily be arbitrary at this time. Their principal value will lie in stricter descriptions and in their offering of possibilities for comparative research.

First, it may be well to discuss some general considerations bearing on our problem. As Hunt and Kogan (50) have pointed out, the task of evaluating psychotherapy is ultimately referable to the general problem of personality assessment. The measurement operations must, in turn, develop from some theoretical basis or, at least, from a set of systematic assumptions. There is, at this time, no explicit common framework that can encompass the different approaches. There are differences in definitions, conceptualizations, and theoretical assumptions as well as differences in specific techniques.

In some cases techniques have been derived, in part, from theoretical assumptions, whereas in the nondirective procedure, for example, a personality theory has been developed from experience with the technique. Within each therapeutic approach it is not possible to establish, on the basis of available research, definite correlations between theory and practice. There is no reason to assume a direct relationship between expressed theory and practiced technique.

From many sources have come data suggesting that the basis for evaluation of common dimensions of therapy may come not from

their theoretical formulations but from the techniques as actually practiced. When experienced therapists are called upon to express their attitudes and consider terms used in the practice of psychotherapy, there emerge many areas of agreement (23).

Fiedler has presented a series of studies (42, 43, 44) in which he used expert and nonexpert therapists from three different approaches—psychoanalytic, nondirective, and Adlerian. Comparisons were first made between the therapists' verbal descriptions of an "ideal therapeutic relationship" in terms of (1) the ability to communicate with the patient, (2) the emotional distance which the therapist determines between the patient and himself, and (3) the status of the therapist in relation to the patient. Using a Q-technique developed by Stephenson (31), the therapists sorted a series of qualitative statements that describe these patient-therapist relationships into categories ranging from the most characteristic to the least characteristic. The intercorrelations of these rating distributions revealed only one general factor which indicated that expert therapists of all approaches agreed more consistently with one another than with nonexperts of their own school. The ability to describe an ideal therapeutic relationship seemed to depend more on the expertness of the therapist than on his theoretical background.

In a second study, comparisons were then made between the therapists' practice as revealed by electrically recorded interviews. Four judges assessed the interviews by sorting the same series of qualitative statements as noted above into categories ranging from most descriptive to least descriptive of the therapy session. Intercorrelations were carried out between these ratings on the practice of therapy and the therapists' verbal concept of the ideal therapeutic relationship noted in the previous study. The expert therapists' interviews resembled this concept more closely than did the nonexperts' interviews. Furthermore, the ratings assessing the experts' sessions correlated more highly with each other than with nonexperts' interviews of the same approach. Factor analyses of each judge's ratings on the therapy sessions consistently revealed one factor, or, rather, two correlated factors, which differentiated the expert therapist from

the nonexpert, regardless of approach. There were no factors that clearly characterized therapists of different schools. Within the limitations of this design, it would appear that the practices of expert therapists with different theoretical backgrounds resemble each other more closely than they do the practice of nonexperts in the same school.*

The importance of these studies lies in their demonstration that an "experience" or "expertness" factor can account for a substantial part of the variance when comparisons are made among therapists of different theoretical approaches, with respect to actual practice and verbal description of ideal practice. These data surely point to the possibility that, in spite of divergent language systems and theoretical elaborations, there exist significant common dimensions in the different approaches to psychotherapy.

THEORY AND TECHNIQUES

In considering the theories underlying the various approaches, some distinction must be made between basic theoretical orientation and secondary elaboration developed to explain the use of more specific techniques. Group therapy is a case in point. Although Slavson's discussion is the one in this book that is focused on group therapy, Hobbs also refers to it from a Rogerian point of view, and Moreno elaborates upon his version in terms of the psychodrama.

All three have in common the specific technique of therapy within a group situation. Because they have different theoretical

* Dr. Hobbs correctly points out in his section (pp. 17 to 18) a finding of the Fiedler studies which revealed one factor showing some differentiation between different approaches, namely, that the nondirective is less tutorial. This finding appears to be valid for three out of the four nondirective therapists, but it is necessary to interpret it in the context of a rather elaborate statistical design. Fiedler, in his third article (44), concluded: "While we have found several factors which clearly differentiate experts from non-experts, only one of the factors has differentiated three therapists of one school from another school . . . there are no factors which characterize therapists of any of the three schools . . . the hypothesis of this series of investigations, that the nature of the therapeutic relationship is a function of expertness rather than school, has thus been further supported."

backgrounds, they have introduced new concepts in their attempts to explain phenomena peculiar to group processes. For example, Slavson (20) considers group therapy identical with individual therapy and bases his theory primarily upon psychoanalytic principles. He discusses transference, catharsis, insight, and other details and then goes on to consider such terms as *universalization*, *dilution*, and *target-multiplicity* as means of describing various group interactions.

Hobbs, although adhering to a nondirective position, makes a distinction between group therapy and individual therapy. The former, according to Hobbs, provides "an immediate opportunity for discovering new and more satisfying ways of relating to people." Changes in the concept of self may be brought about by new kinds of experience with others. In the group situation, each patient has the opportunity to become therapist as well as patient.

Moreno is very definite about the differences between individual and group treatment. He sees the group as a means of stimulating and learning adequate social relationships in a real-life setting. From this have come an emphasis upon group structure and dynamics and the use of special techniques, such as sociometry and role playing. These methods have found a ready acceptance in psychology and psychiatry. Because of its unique language, however, Moreno's (14) elaborate theoretical structure is very difficult to compare with other approaches.

Thus, from the standpoint of theory, group therapy is not a distinctive approach. It may include various combinations and elaborations of a directive, nondirective, or analytic orientation. This is also true of hypnotherapy. Hypnosis is a therapeutic adjunct used in combination with various other techniques, depending upon the orientation of the therapist.

Let us consider first the different theoretical orientations. Here there are a number of ways in which we may approach the problem of comparison. Distinctions can be made between the various orientations in terms of any one of the following:

1. Formal aspects of the therapeutic relationship
 - a. Degree and use of various diagnostic aids

- b. Frequency of sessions and amount of time used in treatment
- c. Physical environment of the therapeutic session
- 2. Attitudes and action of the therapist
 - a. Amount of authority and direction that the therapist assumes
 - b. Degree of depth analysis and active synthesis that the therapist undertakes
 - c. Extent to which the therapist uses support, reflection, desensitization, suggestion, interpretation, or persuasion
- 3. Focus on the patient's communications in the therapeutic relationship
 - a. Concentration on free associations, feeling tones, and emotional attitudes or on problem areas and symptomatic disturbances
 - b. Attention to past history and development or to present events and outside environment
 - c. Analysis of the transference relationship in terms of the reality situation, genetic derivatives, interpersonal relations, or socio-cultural determinants

The three theoretical orientations presented in this book are directive, psychoanalytic, and nondirective, and their interrelations, in terms of the categories listed above, should become more meaningful when considered in the context of the underlying assumptions and objectives of each position.

The Directive Approach

The directive approach urges an eclectic point of view, utilizing contributions from the various sciences, such as medicine, psychology, sociology, and so on, that can shed light on the total activity of the individual. The primary emphasis, however, is on the active re-education of the patient. Therapy, according to this view, should endeavor to regulate and guide the patient's life after the factors favoring or hindering modification have been carefully studied and formulated.

The historical roots of the directive approach are in the active therapies of Dubois (5), Dejerine (4), and Riggs (17). The approach of Dubois was a rational appeal to the intellect and will, with

the development of critical-mindedness and a sense of independence in the patient. Therapy was conducted in the form of encouraging and moralizing conversations and reasoning with the patient, all directed toward the clarification of false ideas and faulty mental habits on which the neurotic symptoms depended.

Dejerine took this method one step further by implicitly recognizing the importance of emotional shocks and traumatic incidents in the development of neuroses. He practiced persuasion techniques in the "re-education of the reason," but combined with ventilation of traumatic incidents, and in the development of a reassuring emotional relationship with the patient.

The use of active re-education was clearly emphasized in the techniques practiced by Riggs. He believed that stress and strains on emotionally overactive people impaired intellectual functioning and produced neurotic symptoms and distortions. It was necessary for the patient to learn principles of satisfactory adjustment to life, and this was accomplished by setting up a well-organized routine in social living, preferably in an institution away from environmental stress. The patient followed a schedule of occupational and recreational activities; he attended lectures and group discussions on the psychology of adjustment; and he had daily interviews with the therapist. All these procedures were directed toward reorienting the patient's thinking and toward developing mature habits of social cooperation.

Probably the most systematic presentation of the eclectic approach is based on the psychobiological principles of therapy developed by Adolf Meyer (12). The focus in this procedure is on all factors that have operated to mold the individual's personality, family background, socioeconomic influences, and significant childhood and adult experiences. Emphasis is on the present meaning of these experiences and on the patient's attitude toward them rather than on unconscious mechanisms.

In the course of treatment pointed questions are asked and areas of discussion are delineated, all pointed toward the association of present symptoms and abnormal reactions with common origins in past and current disturbances. A continuing active synthesis is made of all factors, especially constructive and positive elements, that will

encourage the patient to think things out for himself, gain insight into his problems, and correct disturbing environmental situations.

With this background, Thorne has presented a therapeutic orientation that is concentrated upon marshaling the patient's intellectual resources, training in self-regulation, and attitudinal reorientation. Methods and techniques used in the therapeutic sessions are all directed toward this end. The formal aspects include one to three sessions a week in a face-to-face relationship. The duration of the treatment depends on the conditions of the individual case and may range from a few to several hundred sessions.

Since the therapist directs discussion toward significant problem areas, the initial diagnostic formulation is of major importance. Psychological testing, medical and social data, and especially a longitudinal study of life history are used to understand the dynamics of the individual case. The case-history material may also be used in the therapy itself to give reassurance, promote catharsis, and foster insight.

The communications between patient and therapist are focused on actual situations, both past and present, which have led to current symptomatic disturbances in the form of infantile reactions, erroneous attitudes, and unhealthy habits of thinking and acting. Various techniques, which range from support and reassurance to the disclosure of factual information, are used to re-educate the patient in the development of more constructive and socially approved attitudes and the practice of more rewarding behavior patterns. Although Thorne recognizes the importance of tension release and the establishment of a positive emotional relationship between patient and therapist, the chief tool of treatment is the intelligence of the patient, and the appeal is to his reason and self-respect.

Fundamentally, then, the basic premise of this approach is that pathological habits and attitudes can be identified, diagnosed, and modified by unlearning and relearning, with the therapist acting as a "master educator" who uses the most effective combination of techniques to direct the patient toward a more satisfactory way of life.

The Psychoanalytic Approach

The origin of the psychoanalytic approach was in the use, by Freud, of hypnosis as a treatment technique, following his experience with Charcot and the Nancy school. Together with Breuer, Freud observed that repressed traumatic experiences were important in the development of hysterical symptoms and that under hypnosis the patient was able to talk about these experiences, while at the same time there was a discharge of affect. Thus, the early thinking about analytic therapy was in terms of emotional release or catharsis to undo an early causative trauma.

The underlying assumptions of this approach still rest on the hypothesis that neurosis develops from the repression of vital experiences with important parental agencies, experiences centered around oral, anal, and Oedipal stages in the growth of the child. Such repression is sponsored by fear of the loss of love or fear of punishment from the parents, which has been internalized in the superego. Current thought, however, is centered more on the meaning of these experiences to the patient, on the relationships to present events and to the defense mechanisms of the character structure, than on the mere discovery of sexual trauma.

Therapy is focused on bringing to conscious awareness derivatives of the repressed experiences, and, through the relationship with the therapist, the ego of the patient is strengthened to the point where he can withstand the anxiety associated with this repressed material. The techniques used in the therapeutic procedure are means of facilitating this uncovering process. Thus, the patient must follow the basic rule of free association and tell everything that comes to mind, without thought of coherence or relevancy. He lies on a couch, and the therapist assumes a passive attitude to minimize the influence of current situations and reality considerations. Although analysts may make use of diagnostic aids, such as projective tests, it is primarily the material from free associations and dreams that are the basis for formulation of the diagnostic problem.

In the process of therapy, the patient must recognize and under-

stand the repressed material as derivatives, in an attenuated form, of early fears and conflicts. In order to accomplish this the therapist must deal with the resistances and defensive maneuvers of the adult character structure. The most important technique at his disposal is the transference relationship. In this situation, the patient relates to a new parent figure, the therapist, and "acts out" his neurotic feelings and attitudes derived from experiences during his developmental period. By means of strategically timed interpretations, the therapist exposes the nature of the transference as well as the defenses that the patient has used to perpetuate his neurosis. He helps the patient to make connections between past and current events and to work through his problems by seeing how they condition every aspect of his life. The transference relationship is an intense emotional experience, and, in order to foster it, therapeutic sessions are held four or five times a week. Such depth analysis, which seeks the understanding of neurotic symptoms and defense mechanisms in unconscious genetic origins, takes from two to five years.

In briefer forms of psychoanalytic therapy (3) the therapist takes a more active part and may also use such adjuncts as hypnosis and group therapy. Here greater emphasis is placed on the initial diagnosis of the problem. In this way the therapist is able to focus interviews on significant material and manipulate the transference relationship by assuming roles in accordance with the needs of the patient. Considerable flexibility in methods is used. These may include (1) advice and suggestions about life situations; (2) regulation of number of sessions each week; (3) interruption of therapy for a variable period prior to termination of treatment; and (4) employment of life experiences as a part of the therapy process. All these means are used to bring unconscious conflicts to awareness, deal with resistances, and control certain aspects of the transference relationship.

The Nondirective Approach

The nondirective approach has its historical roots primarily in a modification of analytic therapy by Rank (16) and the relationship therapy of Levy (11) and of Taft (24).

Rank placed great emphasis on the forceful separation of the child from the mother at birth. He believed that this "birth trauma" resulted in two groups of strivings: one, a desire to return to the womb, which expressed itself in a need for dependency; and, two, a desire for rebirth, which appeared as a "will" to grow, to achieve self-actualization. The emphasis in Rankian analysis is on the resolution of the conflict between these two contradictory strivings. It is concerned with the expression of dependency and self-assertion specifically in the therapeutic relationship. The therapist actively concentrates on mobilizing constructive elements in the personality so that the patient can resolve his fears of separation and achieve growth and independence.

In the approach used by Levy and by Taft, the focus is also on the present rather than on the past. Instead of having the patient retrace his developmental steps and relive emotional experiences, feelings and attitudes are handled in terms of the present therapeutic relationship. An essential feature of this approach is the concept that positive growth can be achieved in the therapeutic relationship itself. The emotional interaction between patient and therapist permits the free expression of strivings and feelings with complete acceptance and understanding. In such an atmosphere the patient can realize his potentialities, and through insights gained in this unique relationship, he is able to readapt himself to life situations.

In the nondirective approach the concept of the therapeutic relationship as a medium in which individual growth can be realized has been further developed. The theoretical position, based upon a phenomenological point of view elaborated by Snygg and Combs (21), assumes that behavior is determined by the individual's own perceptual field. Thus, it becomes the task of the therapist to facilitate the patient's exploration of his own perceptions by communicating to the patient an emphatic understanding of the world as he, the patient, sees it. At the same time, the patient is provided with an opportunity to bring about changes in his perception of himself that lead to self-realization and self-enhancement.

The focus is on the individual and not on the problem. No attempt is made to formulate a diagnosis, because it would involve

dangers of subordinating the individual to an evaluation by authority. Instead, the therapist assumes a permissive and accepting attitude in order to allow free expression of the patient's own feelings and attitudes. These communications are emphatically perceived by the therapist, and his understanding and acceptance of them are reflected back to the patient in a tolerant and nonjudgmental way. The response is always to the individual's emotional experience rather than to the intellectual content of his verbalizations. No effort is made to guide him, to provide information, or to give advice; the therapeutic relationship is structured solely in terms of the patient's own pattern of thoughts and feelings. Interviews are conducted one to two times a week in a face-to-face relationship, and therapy may extend from a few to several hundred sessions.

These procedures in nondirective therapy are based on the hypothesis that there are in each individual residual growth potentials which need only to be released to enable the person to achieve maturity. Maladjustment is not due to lack of knowledge or failure in problem solving but rather to a blocking of knowledge by feelings and attitudes that are not understood by the individual. Thus, the main role of the therapist is to provide a unique situation of acceptance and recognition and to refrain from imposing his own patterns and values on the patient, so that self-understanding and growth may take place directly in the therapeutic relationship. The techniques employed—emphatic reflection of feeling and rephrasing of verbalizations—are used to achieve this end: to help the patient clarify facts for himself and recognize his own emotions without fear. In the course of therapy, there is a gradual shift in the content of the material discussed by the patient, from symptoms to explorations involving the self. Growth changes develop in the perception of attitudes toward the self, with more positive appraisals and a more realistic consideration of oneself and one's environment.

It should be clear from the foregoing descriptions that the therapeutic objectives, theory, and techniques of any single approach are highly interrelated. Differences in objectives are most often a reflection of differences in psychological theory and techniques, and the theory and techniques are, in turn, a related outgrowth of a con-

sistent therapeutic point of view. In the case of nondirective therapy, theoretical elaborations followed the empirical testing of techniques, whereas in analytic therapy, there was a concomitant development.

The three approaches presented here differ very distinctly in their basic orientation toward the therapeutic process. Yet, specific techniques used in these approaches may be arrayed on some quantitative dimensions to point up common aspects.* For example, the nondirective position emphasizes "clarification and reflection of feeling" in contrast with "interpretation" in the psychoanalytic approach. If we consider both techniques as different degrees of revelatory interpretation, that is, the degree to which they uncover aspects of personality unrecognized by the patient, then we can observe some relationship between them. In paraphrasing what the patient says so as to focus on feeling tones, the nondirectivist recognizes feelings that are expressed by the patient. The analyst who uses interpretation recognizes feelings before they are expressed or when they are expressed in disguised forms. The directive therapist also responds in an interpretative manner but in terms of the intellectual content of the remarks rather than in terms of the patient's feelings.

Another important aspect of the patient-therapist relationship is concerned with the balance of responsibility between patient and therapist in structuring the interview sessions. In the nondirective approach, the major responsibility for structuring the interviews is left with the patient. In both the directive and the psychoanalytic approaches, the therapists assume greater responsibility, but on very different levels. The directive therapist actively imposes restrictions by asking questions, introducing topics, and channeling the discussion into significant problem areas. The analyst subtly structures the interviews through a constant analysis of resistances and the transference relationship.

* Both Bordin (30) and Collier (34) have proposed various common dimensions or continua for comparing the different approaches. These are specified in terms of patient-therapist relationship variables and different techniques used in therapy.

The investigators believe that with the concept of dimensions or continua in the therapy process, it would become less important to emphasize sharp distinctions between nondirective, directive, or analytic approaches. Rather, the problem would become one of specifying the segments on these continua which will lead to therapeutic progress for specific cases, stages of therapy, and social-field conditions.

With distinctions duly noted, the question arises as to the specific applicability of the different approaches. Unfortunately, there is little that is definitive in this area. Rogers (18) at first set up specific criteria for the use of nondirective therapy, but, after broader experience with this approach, he now believes that it can be used with practically everyone, from mild situational maladjustments to psychotic cases. As a matter of fact, the idea of specifying certain applications is contrary to the basic orientation of nondirective therapy, since it involves the formulation of an initial diagnostic problem. Such a procedure would oppose an atmosphere of equality, which Rogers believes is essential to the therapeutic process.

In general, the nondirective approach, in cases in which it does not produce marked changes, can do relatively little harm, because the patient deals only with material that he is willing and able to discuss. For this reason its scope would appear to be restricted to individuals of relatively sound personality structures in which anxiety elements do not block the emergence of positive growth potentials. Left to his own devices, the patient with serious emotional problems may avoid coming to grips with deep anxieties. He may even choose to retain neurotic defenses, in this way warding off inherent tendencies for self-recognition and growth.

The directive approach may be especially applicable when the objectives of therapy are concentrated on helping the patient to withstand anxieties and stresses of everyday life and to use his abilities more effectively. With its emphasis on the rational solution of problems through a relationship with an authority figure, it may also be effective with certain dependent personalities who are unable to take any decisive action without being forced into situations by an authority. In cases where the individual is endangering himself or others through uncontrolled emotionality or with immature individuals who tend to "act out," a directive approach may be the most effective procedure to use, at least in the initial stages of therapy. Direct therapies would also be applicable with patients who are sufficiently flexible to alter behavior patterns once their distorted attitudes are brought to their attention and clarified.

The psychoanalytic approach, on the other hand, is concerned with investigating and resolving conflicts that underlie distorted attitudes and neurotic behavior patterns. It is concerned with a reorganization of the character structure, and various modifications of it have been used with a wide range of cases. However, since transference is the main tool of psychoanalysis, it is especially applicable to those individuals with whom a transference relationship can be established. In this group are included such syndromes as the conversion hysterics, anxiety neuroses, and certain types of compulsive neurosis and neurotic depressions. In line with this view, analytic therapy would not be effective with psychopaths, who will not, and schizoid personalities, who cannot, withstand the symptomatic suffering of the uncovering process and the transference.

Group therapy can be used within the context of each therapeutic approach—directive, analytic, or nondirective. Depending upon the particular approach, the group is seen as a medium in which the multiple relationships with others affords opportunities for expression of feelings, for gaining a sharpened awareness of neurotic patterns, and for constant reality testing by interactions with manifestations of hostility, fear, and abnormal behavior of other group members. Group therapy is more effective with patients who have some understanding of themselves and thus are able to see their neurotic patterns in a group setting and make connections between the expression of emotion and its relationship to basic character structure.

Hypnosis is not used as an adjunct in nondirective therapy because it involves a relationship in which the therapist imposes his will on the patient. With the directive approach, hypnosis may be used to remove symptoms through direct suggestions and to obtain abreaction of suppressed feelings in such cases as shell shock and anxiety states after accidents. In analytic therapy, the technique of hypnoanalysis may stimulate the recall of traumatic memories and facilitate the production of associations and related emotions. It can also aid in the development and employment of the transference relationship when serious resistances are encountered. However, the

repressed material uncovered during hypnosis must also be dealt with in the waking state so that it can become fully integrated with the ego.

The elaborate group technique of psychodrama is based primarily upon concepts derived from the analytic approach, although it employs a unique terminology. Its primary contribution has been the method of role playing, in which the patient spontaneously acts out his problems in dramatic form with other actors and with the therapist as director of the drama. In the role of actor, the patient is stimulated to give full expression to his feelings and attitudes and in this way to achieve catharsis and desensitization. The resolution of deeper problems and conflicts is further advanced in the patient's relationship to the other actors and to the director. This technique is used within the context of a directive approach and may be especially effective with patients who display a good deal of generalized inhibition.

EVALUATIVE STUDIES

Until recently there have been few objective attempts to determine the effectiveness of specific therapies and almost none concerned with comparative evaluations of different approaches to psychotherapy. Oberndorf (61), writing in 1950, observed that a review of two leading psychoanalytic journals—*The International Journal of Psychoanalysis* and *The Psychoanalytic Quarterly*—over the past ten years revealed “that practically no articles have been devoted to the results of psychoanalytic treatment and very few deal with therapy directly.”

The psychoanalytic literature contains a large number of individual case reports, which are usually included to demonstrate specific aspects of theory or technique. Although these reports certainly offer valuable clinical insights, they can hardly be considered adequately controlled validative data.

Among the other approaches, hypnotherapy, psychodrama, and

directive therapy have also relied primarily upon clinical observations and impressions in evaluating the efficacy of therapy. The non-directive approach and, to a lesser extent, group therapy have taken the lead in utilizing more objective methods to evaluate their therapeutic procedures. The use of experimental methodology does not in itself imply therapeutic effectiveness, but it does offer a greater possibility of eventually demonstrating what happens in the therapy situation.

The evaluative studies that have been reported vary considerably both in method and in content. Some clarification might be obtained by organizing the studies under three broad categories based in part upon the type of criteria employed.

Subjective, or Impressionistic, External Criteria

The first group have, in general, used subjective, or impressionistic, external criteria, such as therapists' opinions in terms of over-all effectiveness, patients' ability to resume productive work, information from family and friends or from case records, and life-history data. These studies usually have involved large numbers of patients who may be assessed at the conclusion of treatment or followed-up at some time after therapy.

In considering these statistical studies it is important to recognize that the criteria for treatment and cure were obtained from case records in different institutions and from different therapists. Such data undoubtedly do not do justice to many problems involved in the evaluation of psychotherapy, but, on the other hand, they represent the only actuarial evidence available at the present time.

Eysenck (39) has made a careful summary of five published reports on the results of psychoanalytic therapy and nineteen reports on eclectic treatment. He has compared them with two studies that cite figures for "spontaneous remission" and recovery without specialized methods of treatment.

The two surveys that provide control data from nontreated patients are those by Landis (55) and by Denker (36). The first study

reported its "baseline" measure in terms of the percentage of neurotic patients discharged annually as recovered or improved from New York state hospitals for the years 1917 through 1934. The consolidated amelioration rate for this group of patients receiving, in the main, custodial care was 72 percent.

Denker surveyed a series of 500 patients who were being treated by general practitioners for incapacitating neurotic disturbances while receiving disability payments from an insurance company. The general treatment used was rest, sedation, and reassurance; and the estimated rate of recovery at the end of a two-year period was the same figure of 72 percent.

The data on analytic therapy involved 760 patients and were collected from institutes in Berlin, Chicago, London, and the Menninger Clinic. The percentage of neurotic cases in the combined cured, much improved, and improved categories ranged from 39 to 67 percent for the five surveys, with an over-all average of 44 percent. In this group, however, about one third of the patients broke off treatment; consequently, the percentage of successful cases in the group that did complete therapy averaged about 66 percent.

The second series of studies with eclectic therapy involved 7293 patients and included a wide variety of approaches used in a number of different hospitals and clinics. The range for the nineteen surveys was from 41 to 77 percent in the combined cured, much improved, and improved categories, with an over-all average of 64 percent.

There are certainly many criticisms which can be leveled at such *ad hoc* actuarial data, especially when there are no consistent standards for defining "improvement" or for estimating the effectiveness of any therapeutic practice. Yet these data are disconcerting, primarily because they are the only figures we have,* but also because

* Statistical evaluative data for the other approaches are very limited. Thorne (25) cites various case material to illustrate the directive approach, and Wolberg (27) presents numerous case studies demonstrating the effectiveness of hypnotherapy in different psychiatric conditions; but neither offers any quantitative results.

The studies of Parrish and Mitchell (64) and of Fantel (40) both describe the use of psychodrama in state mental hospitals. The authors report that this procedure led to improved hospital adjustment and helped in preparing patients for

they demonstrate a good deal of consistency. Regardless of whether neurotic patients are given custodial care, eclectic treatment, analytic therapy, or nondirective counseling, about 65 to 70 percent get "better."

It may well be that such over-all comparisons tend to obscure the specific effects of any single treatment method. For example, certain types of patients may be maximally responsive to analytic therapy, whereas others may benefit more from the use of eclectic methods. If this is so, gross comparisons may tend to obscure such relationships and result in somewhat similar figures. Unfortunately, there are simply no data bearing on this problem. Probably one of the most pressing research needs in this area is studies that will establish in a definitive manner the level of effectiveness of various therapies with respect to specifically diagnosed disorders.

Objective External Criteria

The second group of studies in general employed more objective external criteria, such as psychological tests, self and observer rating scales, independent judges, and sociometric data. These studies usually have a predetermined experimental design and may also include control patients not receiving therapy.

A large number of reports are available in this group, but it is difficult to know where even to begin a comparative evaluation of the different approaches. Various rating scales and psychological tests have been used by different investigators with different therapies,

adjustment outside the hospital. But again, no data are provided for comparison with other approaches or with nontreated cases.

Geller (45), in a survey of 200 state mental hospitals to determine the current status of group psychotherapy, found it in use in about half of the 185 hospitals that replied to the questionnaire. He reports that specific comments about group therapy were very favorable, especially in milder psychiatric conditions. However, there was no quantitative treatment of the data.

In an investigation of the nondirective approach by Bartlett (29), a statistical report is presented on a six-months follow-up of 498 veterans after personal-adjustment counseling. Supervisors evaluated the veterans' progress before, directly after, and six months after therapy. Thirty percent were rated as much improved, 44 percent as somewhat improved, and 18 percent as unimproved. The number of interviews was also correlated with the degree of improvement.

but no single instrument has shown a consistent validity in measuring the effects of therapy. In a number of cases in which cross-validation studies are available, clinical ratings or qualitative ratings of test protocols may show remarkable improvement with no concomitant quantitative changes in objective test data. Also, in cases in which one test was used to evaluate a given therapy and another test with a different approach, comparisons between therapies are hardly possible. Before a comparative evaluation of the various approaches can be undertaken, it is necessary to define clearly criteria of change that are both reliable and applicable to all the approaches and, further, to show some consistent relationship between these different criteria.*

* The difficulties encountered in attempting to make any comparative evaluation are quite apparent, even from a limited review of the many different behavioral indices and testing techniques used to evaluate the various approaches.

Wiener and Phillips (75) administered the *Minnesota Multiphasic Personality Inventory* both before and every two months during an eight-month "modified psychoanalysis." Comparisons between test profiles and the subject's own descriptions of therapy showed agreement on an originally severe anxiety state, alleviation of symptoms, and unresolved basic conflicts at the termination of therapy.

In investigations of group therapy, Rashkis and Shaskan (66) also used the MMPI. Klopfer (53) gave the *Rorschach Test*, and Coffey, et al. (33) used self ratings and ratings by members and group leaders. The authors of the first study report consistent improvement on the nine diagnostic scales of the MMPI. Klopfer found marked positive changes in three out of nine cases in terms of Rorschach signs, whereas Coffey's data on ratings showed general agreement that therapy was beneficial. But the results did not reveal any specific direction of change.

In an elaborate study using the MMPI with directive treatment methods, Schofield (70) compared two test profiles given to 124 patients before and after therapy. There were no significant test-profile changes noted, and the author was unable to derive a scale of items that would successfully predict personality changes following therapy. There was little relationship between this test and independent clinical criteria of improvement. Morton (58), using the *Rotter Incomplete Sentence Test* and ratings by judges on recorded initial and final interviews, evaluated the effects of a "relatively directive" brief psychotherapy. He found remarkable agreement among the improvement ratings of the judges and between these ratings and the test data. Also, eighteen out of twenty patients improved, but two did not. This was in contrast to a control group in which one improved, three were questionable, four were worse, and twelve remained the same.

Probably those dealing with the nondirective approach have carried out the greatest number of studies using objective testing instruments and pre- and post-therapy designs. Muench (60), administering both the *Bell Adjustment Inventory* and the *Kent-Rosanoff Word Association Test*, showed significant changes in the areas of health and emotional adjustment on the Bell and improvement in four

If we restrict ourselves to one testing instrument in evaluating the effectiveness of nondirective therapy, we have a series of five studies with the *Rorschach Test* on 125 patients tested before and after therapy and thirty-five matched control cases.

In the first study by Muench (60), the Rorschach was included in a test battery administered to twelve patients before and after therapy. Employing a number of quantitative indices of adjustment and maladjustment developed by Hertz and Klopfer, he found significant positive changes after therapy. Each scoring configuration showed improvement in at least nine of the twelve cases, and these were related to clinical judgments.

In a subsequent study by Carr (32), however, the Rorschach was administered to nine cases before and after treatment. Employing essentially the same criteria of improvement as Muench did, he found no quantitative differences following therapy. The test protocols were also analyzed independently by a clinician, who found that there was no change in five cases and that the remaining four were only slightly improved.

Mosak (59) followed this work up with a study in which the Rorschach, together with other tests, was given to twenty-eight neurotic patients also before and after therapy. In agreement with Carr, the quantitative scores of adjustment again showed no consistent changes after treatment. But this time, three experienced clinicians, judging the test protocols, found that two cases were much improved,

other adjustment scales. With the word list, he found reliable shifts in the direction of more normal associations.

Mosak (59) also used the Bell, the MMPI, and the Hildreth Feeling-Attitude Scales. Improvement was again noted on all five scales of the Bell, with the greatest change taking place in emotional and health adjustment. On the Hildreth Scales, the patients rated themselves more positively after therapy on their feeling and mental states, attitudes toward work and toward others, energy level, and degree of optimism regarding the future. The MMPI showed positive shifts on five of the nine diagnostic scales, with the greatest changes found on the Depression and Schizophrenia scales. It is interesting to note that these two scales showed the least change in the study on group therapy by Rashkis and Shaskan cited above. Cowen and Combs (35) used the *Bernreuter Personality Inventory* and found positive shifts in Neurotic Tendency, Introversion, Confidence, and Sociability, but no significant changes were noted on scores for Self-sufficiency and Dominance.

half the group were somewhat improved, and the rest were considered unchanged.

A more elaborate study with the Rorschach, involving fifty-six patients in individual and group nondirective therapy with thirteen therapists, was carried out by Haimowitz (46). She also included a control group of fifteen subjects equated for age, sex, and education. This time both quantitative test scores and qualitative analyses of the protocols showed consistent positive changes in the patient group with no significant differences noted in the controls. The quantitative indices used in the present study were the group of neurotic signs developed by Harrower (47), and these showed a statistically reliable mean decrease from 3.0 to 2.0 after therapy. Ten scales for evaluating the Rorschach, based on the therapeutic concepts of nondirective therapy, were developed. These included quality of reality orientation, degree of anxiety, degree of dependency, self attitudes, degree of acceptance of emotionality, adequacy of intellectual functioning, degree of spontaneity-flexibility, personality integration, attitudes toward others, and quality of adjustment to emotional problems. Nine of the ten ratings showed a consistent shift in the positive direction, with no change noted on the spontaneity-flexibility scale. In ten cases followed up more than a year after therapy, six patients continued to demonstrate a steady gain on the adjustment ratings while four cases showed either no further improvement or some regression toward the pre-therapy level.

In a study made in another clinic, Love (56) included the Rorschach in a battery of tests administered to twenty veteran patients and twenty matched controls before and after nondirective therapy. The records were analyzed quantitatively, using the signs employed by Muench and Carr, and qualitatively by three experienced clinicians. There were no significant differences found between the patient and the control groups on the quantitative signs of adjustment. A Chi-square analysis of all the judges' ratings revealed significant positive differences on four adjustment scales: over-all adjustment, emotional stability, anxiety, and adjustment in interpersonal rela-

tions. There were no differences found on the ratings of intellectual functioning and constriction-rigidity.

These series of studies would seem to indicate that changes brought about by therapy can be demonstrated on the Rorschach test when patterns of responses are considered. In four out of five studies, clinicians were able to detect positive changes on various scales between pre- and post-therapy records, and, where controls were available, the clinicians were able to distinguish their records from the changes noted in the patient group. From descriptions of the many different scales it is difficult to know exactly what it is that is changed. Rogers (18), in line with his theoretical position, believes that these test data indicate a basic unification and integration of personality with "a greater degree of acceptance of self and of emotionality as a part of self," accompanied by decreased anxiety and more constructive feelings and attitudes.

Changes That Take Place during Therapy Procedure

The third group of studies have been primarily concerned with evaluating changes that take place during the therapy procedure itself. By means of internal criteria, that is, objective measures based on the analysis of interview content, these studies have attempted to develop reliable measures for differentiating "successful" and "unsuccessful" therapy cases.

Nondirectivists have taken the lead in developing internal criteria based on the theoretical assumptions of their approach. A considerable amount of research data that is concerned both with defining successful therapy in terms of intrinsic indices and with describing changes in the therapy process itself has been accumulated (18) (see also Chapter 1).

There is some question, however, as to whether analyses of interview content represent effects of a specific approach or are the result of generalized interpersonal relationships between patient and therapist. Hathaway (48) points out that one would expect certain cul-

tural patterns of behavior to be operative where there is some measure of rapport in the social situation.

One example of such behavior might be termed the "hello-goodbye" pattern. The more acceptable or "face-saving" role for the patient seeking help would be the presentation of his personal problems and difficulties in the initial stages of therapy. Then, toward the termination of therapy, he would be more likely to seek some closure through good will or appreciative expressions and summary remarks. Such a pattern would not be specific to any particular approach.

Another example is found in the similarity of results obtained by Raimy (65) and Dollard and Mowrer (37), who used measurement operations derived from distinctly different theoretical orientations. By measuring changes in self-evaluation in records of therapy interviews, Raimy was able to differentiate between "successful" and "unsuccessful" cases. He had four judges rate units of verbatim interviews for fourteen clients on the basis of positive, negative, or ambivalent feelings. There was a marked change from expressions of negative and ambivalent self-references at the beginning of therapy to an emphasis on positive feelings about the self at the conclusion of the successful cases. An independent appraisal of therapy was based on ratings of the therapists involved.

From an entirely different set of assumptions, Dollard and Mowrer have developed a "discomfort-relief quotient" to measure tension changes in written records. Using a drive-reduction theory of learning, they hypothesized that different levels of tension might be prognostic of success or failure in social casework. The index is obtained by having judges classify thought units as expressions of "discomfort" or "relief" or as "O" (lacking in tension). The DRQ is then determined by dividing the number of discomfort units by the number of discomfort-plus-relief units for any given record.

Kaufman and Raimy (52) compared both the tension index and the self-evaluation procedure on seventeen verbatim interviews taken from recordings of nondirective therapy cases. The two methods of measuring change in interview records produced essentially similar

results. A rank order correlation between the two indices for each of the seventeen interviews resulted in a rho of .84.

Each procedure was derived from a different theoretical position. Dollard and Mowrer believe that a reduction in tension associated with learning accounts for progress in treatment, whereas Raimy assumes that changes in therapy are brought about by a reorganization of the individual's perception of himself. Yet the measurement operations derived from these different orientations resulted in essentially the same quantitative data. Before analyses of interview content can be considered indicative of a specific therapeutic approach, it is, perhaps, first necessary to establish consistent relationships between such measurements and independent external criteria directly related to the specific approach.

In arriving at some sort of summary of these evaluative studies, emphasis may well be focused on the problem of specificity. There is no reason to believe, on the basis of present evidence, that any one approach is uniquely superior for all cases; rather, the available data seem to indicate that all the various approaches are successful to some extent—at least in some cases. The specific problem is one of determining which patients improve and how much they improve and which patients do not improve with a given therapy. This type of research is, of course, contingent upon the attainment of a standard, objective evaluation of a patient's basic personality patterns, and, at present, it is a completely uncharted field.

TOWARD A COMMON ORIENTATION

Any regrouping or reclassifying of the various approaches must necessarily be very tentative and arbitrary. There is simply no substantial empirical data upon which to base definitive comparisons. Also, the different language systems, specifically connotative in the theoretical formulations of a given approach, may lose their meaning when translated into broader terms. Perhaps the best that

can be done at present is some clarification of the common problems and concepts involved in the various approaches to psychotherapy.

Let us begin by making explicit a rather obvious proposition: the practice of psychotherapy is what may be called an applied art, analogous to the practice of organic medicine. Both depend, to a great extent, upon the experience and skill of the practitioner. Any evaluative study comparing different approaches would inevitably attribute a good deal of the variance to the "expertness" of the practitioner, as was apparent in the Fiedler studies.

A central problem, common to all the approaches, involves a better understanding of what may constitute a "good" therapist in terms of training, experience, and personality complex. There have been few studies directly concerned with this aspect of therapy, probably with good reason. For one thing, therapists, in the main, seem very reluctant to offer themselves as subjects of experimentation. For another, such problems bring up the ever-present difficulties of criteria, controls, and the disentangling of relationships between theoretical orientation and the training, experience, and personality factors.

The same difficulties that were encountered in handling the therapist variable would also be encountered in studying other variables during the therapy process or, for that matter, in any research attempting to evaluate the effect of variations in an independent variable upon performance on a dependent variable. As Edwards and Cronbach (38) have pointed out, the essential problem in evaluating therapy is: How did this procedure change this individual? Such a question is basically similar to the questions that have been asked in psychology and education for a long time. The important difference lies in the greater degree of complexity found in dealing with therapy.

Watson (74) has proposed a breakdown of this complexity in terms of four broad categories: (1) variables dealing with data on the patient, (2) situational variables, (3) variables in the therapy process itself, and (4) therapist variables. Edwards and Cronbach (38) have offered a similar classification. One cannot deny that these variables are involved in the therapy process. But the difficulty

of specifically delineating what must be included under these categories and how they are to be measured remains. It is here that the polemic language systems of the different approaches prove unsatisfactory for comparative evaluation.

The Therapist Variable

With the complexity of the problem duly noted, it would still seem that the therapist variable offers one point of departure, if only for the purpose of obtaining initial descriptive data. There are many objective indices describing therapists; some are concomitant with theoretical orientation, and others cut across the different approaches. These could be used to investigate significant features of the therapy process, independent of any specific approach. Some examples of measurement operations that may be utilized in evaluating therapists are detailed in part here:

1. Training dimension
 - a. Formal training in terms of medical, psychological, or social work degrees, postgraduate courses, and range of adjunct academic work
 - b. Specification of training in terms of theoretical orientation
 - c. Professional training in terms of personal therapy, training analysis, and practicum in controlled analysis and supervised therapy
2. Experience dimension
 - a. Extent of experience in terms of length of time having practiced therapy, time now spent in therapeutic practice, and associated activities
 - b. Content of experience in terms of cases worked with, based on age, sex, diagnosis, and problem-area groupings
 - c. Experience status in terms of teaching, training, and supervisory positions
3. Personality dimension
 - a. Professional opinions, subgoals, and interest areas as determined by standardized questionnaire data

- b. Assessment of personality characteristics and problem areas as determined by standard assessment procedures, tests, interviews, and life-history data
- c. Assessment of the therapist's comparative ability to evaluate different problem areas in therapy, utilizing various diagnosis, age, and sex groupings

Such multidimensional comparisons of therapists from different approaches would be a formidable research task indeed, but the Fiedler studies have certainly indicated both its feasibility and its significance. But until more of these studies have been made, we can offer only tentative hypotheses regarding the common elements that might emerge from a concentrated investigation of the therapist variable.*

To begin with, the evaluative studies certainly did not indicate a marked preference for one approach over the others. Here again all the approaches appear to be successful to some extent—at least in some cases. Yet in theory these different approaches tend to stress certain aspects of the therapy process more than others. How might this be related to our proposed data on the therapist variable?

A therapist, because of various personality characteristics, may identify himself with a given theoretical orientation. These same personality characteristics also help him to be more successful in handling certain problem areas in therapy. For example, he may be more sensitive to these areas in other people and thus better able to

* A recent study by Whitehorn and Betz on the relationships between schizophrenic patients and their therapists demonstrates the effect of the therapist variable. One hundred patients treated by fourteen physicians were divided into two groups. In the A group, treated by seven therapists, 75 percent of the patients were improved at discharge. In the B group, treated by seven different therapists, only 27 percent were improved.

From analysis of nurses' notes, charts, conference notes, case records, and physicians' notes, comparisons were made as to differences in the way the therapists worked with these patients and in the way in which patients responded. There were reliable differences between these two groups of therapists in the extent to which they were able (1) to grasp the personal meaning and motivation of the patient's behavior; (2) to gain a trusted, confidential relationship with him; and (3) to participate in an active, personal way in the patient's day-to-day progress. (Whitehorn, J. C., and B. J. Betz. A study of psychotherapeutic relationships between physicians and schizophrenic patients. *Am. J. Psychiat.*, 111:321-331, 1954.)

sympathize with and understand such cases, or he may be able to assume a therapeutic role that ensures a more effective patient-therapist relationship in these cases. The original identification with the theoretical orientation is fostered because the same problem areas and therapeutic roles are stressed by that approach.

Essentially, then, we have a concomitant reinforcing relationship between the theoretical orientation and certain personality characteristics of the therapist which may be expressed on the experience dimension in terms of greater success in handling certain problem areas in therapy. With more extensive experience involving various types of case material, therapists of different schools would tend to deviate from orthodoxy and toward greater agreement on the actual practice of psychotherapy.

Certainly each approach has an important contribution to make in the emphasizing of some significant aspect of this complex patient-therapist relationship. Specific techniques may include working through unconscious motivations (psychoanalysis), clarifying feelings and perceptions (nondirective), training in the rational solution of problems (directive), working through interpersonal relationships (group therapy), catharsis and symptom removal (hypnotherapy), abreaction and acting out (psychodrama). In actual practice, in the very complex interaction of patient and therapist, there may well be a number of different ways to reach desired therapeutic goals.

In theory, however, it is important to understand that an adequate theory of therapy must be capable of explaining the effectiveness of any therapeutic approach. It would be possible, perhaps, to start with the language of psychoanalytic theory and then to go on to hypothesize why nondirective, directive, psychodrama, or any other approach might sometimes be effective in therapeutic practice. But here we are interested in developing a basis for a common orientation apart from the language system of any single approach.

One central concept, which has found general agreement, is the proposition that psychotherapy is essentially an educative or training process (1, 7, 13, 18, 19, 21, 26, 78, 82, 85, 87). In the patient-therapist relationship, therapeutic techniques are directed toward the

provision of the most favorable conditions in which learning and reintegration may take place.

Starting with this basic premise, we may go on to consider three primary aspects of this educative process. The first problem is concerned with specification of the original aberrant learning leading to neurotic behavior, that is, the delineation and relative importance of specific traumatic events and generalized chronic environmental experiences. If behavior pathology and the choice of neurosis can be defined by a circumscribed set of aberrant learning conditions, it would follow that therapy could be more effective by concentrating on these conditions.

The second problem is concerned with specification of the conditions under which this aberrant learning is elaborated upon and generalized to other behavior. In normal learning, habits and attitudes that are unrealistic and nonadaptive are ordinarily self-corrective or self-eliminating. Neurotic behavior, on the other hand, is self-defeating, nonadaptive, and, at the same time, self-perpetuating.

Finally, the third problem is concerned with specification of the conditions under which therapeutic learning may be facilitated in the patient-therapist relationship.

Basis of Aberrant Learning

Psychoanalytic theory and the various modifications of it have been the only systematic attempts to consider those events which may fixate reactions fundamental to neurotic behavior. Although directive therapy does explicitly recognize the importance of identifying etiological factors, these factors have neither been clearly specified nor related to choice of neurosis. Instead, a broad psychological eclecticism is developed, with contributions from many areas in medicine and psychology. Actually, there is very little in such areas as behaviorist, experimental, and Gestalt psychology directly concerned with specifying the basis of aberrant learning for the various pathological conditions except, perhaps, broad generalities.

The nondirective approach, with its de-emphasis on diagnosis in

the traditional sense, has not concentrated upon defining specific needs and specific responses to these needs in the developmental history of the individual. Rather, it has concerned itself with a generalized self-concept, which may be defined as a differentiated sub-total of the organism's perceptual field. Tensions and psychological maladjustments are assumed to develop when experiences as perceived are not accepted into this organized self or are inconsistent with or threatening to the self. Many examples of such experiences are noted in the nondirective literature, but these have no validity independent of the experiencing individual's perceptual field. Rogers believes that generalizations and principles may be derived from studies based on the internal frame of reference of the individual (his own unique perceptions), but, as yet, they have not been defined in terms of specific learning conditions.

Freud (7) at first believed that the psychoneuroses might be caused by associated specific experiences which, because of their intense psychic pain, fixate various responses whose original connections are forgotten. He separated these from certain conditions, termed "actual neuroses," which he attributed to toxic effects due to disturbances in sexual metabolism. Freud later considered both these factors to be only precipitating circumstances in psychoneuroses which may determine, in part, symptom formation.

Another early etiologic theory was concerned with infantile traumata, especially sexual seduction in early childhood. From his analysis of case material, Freud consistently found screen memories related to this theme. But such fantasies were also operative in normal childhood and thus could not, without other conditions, account for the development of neurosis. However, these early considerations led to the idea that strengthening of responses, through excessive gratification of infantile impulses, would result in stronger fixation when frustration occurred in later life.

The frustration theory was the one most consistently developed by Freud and his followers. According to the central hypothesis, the origin of neurosis is due to the frustration of instinctual impulses by social and cultural experience. More specifically, major emphasis

is placed upon the Oedipal situations, in which incestuous wishes directed toward one of the parents are frustrated by social demands. Pre-Oedipal conflicts are concerned with reactions to, among other events, weaning, toilet training, and sibling rivalry. Chronic emotional experiences in the environment, such as parental rejection, hostile attitudes, and so on, have considerable influence in ego formation and in continuing the relational context of these conflict situations.

Traumatic fixation at a specific stage of development, dependent in part upon excessive gratification or deprivation at that stage, is a basic factor in the choice of neurosis. Anxiety-producing situations that occur in later childhood and maturity are effective only in so far as they reactivate pre-Oedipal or Oedipal conflicts. In these circumstances, infantile conflicts and patterns are revived with neurotic symptoms as a negative or converted expression of the pregenital libidinal fixations. Thus, in essence, neurosis is due to repression of infantile fears and conflicts which continually forces the individual "to act in the present as if he were living in the past."

The "dynamic-cultural" school of psychoanalysis, among whom are Horney (9), Fromm (6), and Sullivan (22), distinguishes less sharply between etiological and precipitating situations and places primary emphasis upon cultural factors in the formation of need systems. Sociocultural determinants, instead of acting simply as frustrating or blocking agents, may also have considerable influence in the formation of basic conflicts. Neurotic patterns are the result of continuing environmental conditions which give rise to incompatible attitudes and modes of behavior. Specific interpersonal relationships that may lead to conflicts include authoritarian and dominating attitudes of the parents, which may arouse resentment and hostility, a lack of genuine warmth and affection, and inconsistent patterns of overindulgence and rejection. Such chronic emotional relationships thwart the individual's striving for acceptance and independence and lead to feelings of anxiety and insecurity and self-destructive tendencies.

Dollard and Miller (78) have reinterpreted psychoanalytic con-

cepts into a learning framework.* In neurotic behavior strong drives, such as anxiety or guilt, produce a conflict situation by preventing the occurrence of responses that normally would reduce other drives, such as sex or aggression. This conflict between two strong drives results in symptom formation and neurotic tension. The symptoms are further reinforced with "inhibition of the cue-producing responses which mediate thinking and reasoning," because symptoms also tend to reduce the tension. The individual becomes unable to "label" his own conflicts and use his higher mental processes in their resolution.

Conflict situations have their roots in important sociocultural factors which influence the formation of learned drives. For example, social pressures in the weaning process and in cleanliness and early sex training may produce a conflict between the expression of anger in response to frustration and the feeling of anxiety culturally attached to hostile behavior. Conflicts may also be centered around frustrated mobility and aspirations predetermined by parental demand and social conditions. Before adaptive behavior responses can be elicited, it is necessary to reduce the competing drives which have led to the conflict situations.

Perpetuation of Aberrant Learning

Neurotic behavior carries along with it a considerable amount of pain and misery. Symptomatic reactions are nonadaptive

* Their learning theory may be characterized briefly as follows: The basic variables of *drive*, *cue*, *response*, and *reward* set up the conditions under which a response and a cue stimulus may become connected. Drives are strong stimuli which impel actions, whereas cues determine the time, place, and type of response that will be made. Many stimuli vary both quantitatively and qualitatively; they may have drive value, depending on their strength, or they may have cue value, depending on their distinctiveness. If the first response is not rewarded by an event reducing the drive, this response disappears, and others take its place. As successive responses are not rewarded, random behavior usually follows. On the other hand, if one response is rewarded, a strengthening between the cue and the response takes place, so that next time, when the drive and cues are present, the same response is likely to occur. The strengthening of the cue-response connection is the essence of learning.

The primary drives, such as hunger and pain, are conditioned by society and are replaced by acquired drives or social attitudes. For example, upon the primary drive of pain may be built the secondary drives of anxiety or guilt.

and self-defeating. Yet the individual erects an elaborate defense system to perpetuate such behavior. The responses are continued and generalized to other areas, even though they may bring added suffering. In the treatment of neurosis, Kubie (10) has emphasized this interaction between symptoms of the underlying neurotic process and secondary elaborations resulting from maladaptive distortions in the personality. A basic problem in therapy is concerned with the way in which the patient uses his intellectual and perceptual apparatus to perpetuate his neurosis.

Analytic theory has attempted to handle the problem in two ways. Freud, at first, believed that symptomatic nonadaptive behavior "may serve as a relief for the patient by gratifying another part of the psychic structure." Various modifications of this position have been advanced. For example, the nondirectionists have proposed that neurotic behavior may serve to maintain self-integrity and self-consistency and also that such "security-maintaining trends" may be only partly successful because they conflict with one another and thus produce further anxiety situations (19). Later Freud postulated a repetition compulsion which went beyond the pleasure principle and was the instinctual basis for perpetuation of the neurosis. However, as Kubie (10) has pointed out, such a concept is descriptive and has little explanatory value. "The neurotic pattern which finally persists, and which becomes most repetitive . . . proves invariably to have been the one that served the largest amount of neurotic demands."

Another approach to the problem of the perpetuation of aberrant learning is that presented by Mowrer (82) and based upon his two-factor theory of learning. Essentially this theory holds that there are two different kinds of learning: problem-solving, which results in the acquisition of voluntary response patterns or habits, and conditioning, which leads to the establishment of involuntary emotional responses and feeling tones. The former depends upon reward conditions and is mediated through the central nervous system and skeletal musculature; the latter involves the principle of contiguity

and the autonomic nervous system. Emotional reactions, such as anxiety or fear, acquired through conditioning may act as secondary drives, the reduction of which reinforces problem-solving behavior.

According to Mowrer's view, neurotic symptoms are the result of a "learning deficit," the failure to incorporate societal codes and mores into the structure of the ego, which, in turn, leads to a lack of constructive behavioral patterns. The neurotic individual has unpleasant emotional reactions because he continues to engage in habits that actively condition the unpleasant emotions through the behavior they elicit from others.*

Horney (8) brings up this same point in her concept of the vicious circle:

. . . an individual may attempt to maintain his security by adopting an overbearing and superior attitude. He would not have taken

* An experimental analogue in animal learning, cited by Mowrer (82, Chap. IX), is instructive.

If a rat is placed at one end of a straight alley maze with an electrified floor grid and a safe compartment at the other end, he will soon learn to run into the compartment when shock comes on after a period of ten seconds. This conditioned avoidance response can be extinguished if the shock is discontinued for a number of trials.

However, after the response is conditioned, if the floor grid before the safe compartment is electrified and the animal always shocked there, the rat will still continue to run into it, even though he never experiences shock again on the other part of the alley. This behavior is abnormal; the animal could avoid punishment by not running at all. Yet he continues to run, even though punished every time.

Mowrer attempts to explain this nonadaptive behavior by invoking his two-factor theory of learning. An involuntary conditioned response of fear (sign learning) is established in the animal by the act of placing him in the alley. Through repeated association with pain, the fear, as a danger signal, comes to be aroused each time that the rat is put in the apparatus. The running response effectively reduces this fear feeling by carrying the animal to the safety compartment (law of effect learning). Nonadaptive behavior thus perpetuates itself by reducing fear or anxiety while, at the same time, providing the environmental conditions that continue to "reinforce" the fear state.

A procedure used for extinguishing this response is also interesting in terms of therapy. Increasing the distinctiveness between the two ends of the alley by using different colors and patterns will cause the animal to discontinue running if he receives shock only in front of the compartment. When there is a sharp discrimination between shock at the starting point and shock before the compartment, the fear is no longer generalized, and the nonadaptive response is eliminated.

this attitude unless he felt rejected and disliked (insecure). But this very attitude makes people dislike him more, which in turn reinforces in him the necessity for overbearing attitudes, etc.

Hilgard (79) has made a penetrating analysis of these defense mechanisms in terms of the self-concept as an expression of social interactions. Neurotic behavior patterns attempt to allay feelings of anxiety and guilt and to maintain some degree of security through denial and disguise. They thwart ego growth and maturation and perpetuate themselves through association with strong tension states which they hopelessly attempt to reduce.

The patterning of this behavior is built up out of interpersonal experiences within a cultural framework. They may be means, elaborated by the individual, of coping with feelings of helplessness, isolation, and fear, arising from residuals in a potentially hostile world where the child feels isolated and helpless (9). Or, again, they may reside in fundamental security attitudes, which arise in conflicts between a need for approval from a parental figure and a need for independence (6). Whatever the form of interaction with original aberrant learning, the secondary elaborations maintain the continuity of individual personality characteristics. They perpetuate the conflicts established in the early developmental periods and continue the anxiety and guilt through their action in interpersonal relationships. The therapeutic process, if it is to be effective, must first deal with the resistances provided by these socially learned habits and attitudes.

Facilitation of Therapeutic Learning

The purpose of the therapist-patient relationship is to provide optimal conditions for essential learning. Directive therapy recommends a variety of procedures: suggestion and persuasion, semantic re-education, perceptual retraining, reassurance, and so on, each useful under certain circumstances. But Thorne, more specifically, emphasizes what might be considered a direct attack on the problem. Training in self-regulation and self-control may be accomplished through the maximizing of one's intellectual resources and the achievement of insight into one's behavior.

Although intellectual recognition of aberrant learning may be a necessary condition in the educative process, it is by no means a sufficient one. In many cases psychotherapy does not aim at bringing about personality changes, but it is concentrated on helping the patient to withstand anxieties and stresses of everyday life and to use his abilities more effectively. In such cases, the achievement of insight may be a desirable end goal in therapy.

However, studies in different areas of psychology (77, 83, 84) have consistently revealed the importance of emotion in the organization of memories. The nondirective approach lays particular stress upon emotional elements in the therapeutic relationship. By providing a nonthreatening, emphatic atmosphere, the therapist acts as a potent eliciter of feelings and attitudes. In this climate of acceptance, the patient provides his own learning situation, dependent wholly upon the individual's capacity for growth. The central hypothesis of nondirective therapy holds that if the therapist "can provide understanding of the way the client seems to himself at this (each) moment, he can do the rest."

The role of emotion in the learning process constitutes the essence of therapy. Other therapeutic techniques are useful only in so far as they make essential learning possible. Abreaction and catharsis release tensions and stresses associated with repressed material. Reassurance and support provide an opportunity for learning and reintegration to take place.

The patient must learn to recognize, to experience emotionally, and to handle those very features of his personality which he has dedicated himself to keeping out of sight. However, reliance upon a spontaneous "growth" toward reintegration does not constitute a rational therapy. Another view proposed by psychoanalytic theory is that of the transference relationship. In this situation, original pathogenic conflicts are represented with lesser intensity, but with sufficient vividness to make them realistic. The therapist, in assuming a role different from that of the parent, produces what Alexander (1) has termed the "corrective emotional experience." It may be that, in our culture, a nonthreatening, accepting attitude most often constitutes an effective therapeutic role. The transference cannot be ac-

complished, however, by "reflection of feeling"; it depends upon an intense emotional relationship between patient and therapist.

The resolution of this relationship is undertaken in the "working through" process. The emotional experience and insights of the patient are "reinforced" by repetitive, precise verbalizations, by connecting them with the patient's past and present experiences. The stimuli for anxiety are reinstated symbolically in the transference relationship and then diminished by the comfort-producing reactions of the therapist. By providing an identification model, the therapist helps the patient to formulate rational goals and acquire new behavior patterns. Understanding is thus achieved only through the *conscious* mastery of conflictual tension systems.*

* Exactly how the conscious mastery of conflicts is accomplished actually is the basic issue in psychotherapy. As already noted, directive therapy tries to achieve this through the patient's intellectual recognition of his aberrant learning, certainly a direct attack on the problem. The nondirective approach, on the other hand, attempts to handle the problem by postulating a spontaneous growth toward voluntary behavior following the expression of verbal cues in an emotionally permissive and acceptive atmosphere. In psychoanalytic therapy, the transference relationship is a process in which the early learning stages of childhood that normally result in the development of voluntary behavior are repeated, this time, within the context of rewarding emotional experience. The use of other specialized techniques implies that such essential learning may be facilitated, in some cases, in multiple interpersonal relationships with peers, as in group therapy, or in "acting out" and giving full expression to acts and thoughts with appropriate feedback from others, as in the psychodrama.

In learning terms, Shaffer (85) has presented an analysis of psychotherapy based primarily upon the function of language in the control of behavior. Briefly, he proposes that the maladjusted person does not respond verbally to significant aspects of a situation because recall may be painful and conflict-producing. He represses or inhibits verbal expression of his problems and thus achieves partial adjustment. At the same time, this verbal inefficiency prevents his making more effective discriminative responses by restricting the number of cues available. Normal behavior depends upon the voluntary choice reactions learned through reinforcement by self-signaling verbal and gestural stimuli. The neurotic's lack of self-control is often observed in his inability to act even though he knows what he should do. There are no reliable "connections between his own words and thoughts and his effective behavior." Psychotherapy, then, should be directed toward (1) overcoming resistances and reinstating the patient's own verbal cues and (2) reinforcing appropriate behavior responses to these cues.

Shaw (86) has presented an approach to therapy in learning terms based, in part, on Mowrer's suggestion that maladjustive behavior may persist because it has immediately rewarding but more remote punishing consequences. An animal experiment by Mowrer and Ullman (82) indicated that responses may be influenced by

Finally, in the generalization of this new learning to interpersonal relationships outside the interview sessions, the patient affects changes in his behavior which will in turn elicit more rewarding behavior from others. Thus, by acting differently, he helps to create the social environment that will reinforce, on a reality level, the essential learning achieved in therapy. In "changed reaction-sensitivities" and "increased flexibility of behavior" (80), the therapeutic gains are consolidated in the actual process of living.

What has been gained by this attempt to derive a common orientation? At the outset we note that a comparative view of psychotherapeutic theory could be sketched only in very broad terms. The significant details were still primarily at the stage of divergent points of view and untested hypotheses. Yet these hypotheses, if pursued, modified, and amplified, offer some promise of developing into a consistent conceptual framework for psychotherapy.

Perhaps what is most needed at this time is an integrated program of research organized in terms of common concepts. Hilgard (79) has envisioned a laboratory of psychodynamics wherein research workers from various fields would concentrate on solving the problem of human motivation. In such a place subjects could be used as experimental designs dictate, in the control of variables and the precise testing of hypotheses. One significant area of study, based on his theory of the self-concept, might be concerned with the socialization of the child, the development of his symbolic thinking, and the influence of important people in his environment.

On another level, Hunt (49) has proposed a multidimensional research program designed to discover "what kind of psychotherapy works with what kinds of patients." He would include therapists

the temporal order as well as by the nature of their consequences. Thus, an immediately rewarding consequence may outweigh a greater but more remote punishing consequence.

Shaw has proposed that the punishing consequences of the patient's neurotic behavior should be made more available to him. Therapy should concentrate first on establishing conscious recognition of the punishing effect of the patient's maladjustive behavior. With the inhibition of these responses, therapy could be directed toward helping the patient acquire and carry out adaptive patterns of behavior by consistently rewarding this behavior in the therapeutic situation.

from different approaches, both experts and novices, who would be allotted patients of various diagnostic categories. The data would include (a) measures on the patient, his problems, and characteristics; (b) measures on the interview content to obtain information on the therapist and his interaction with the patient; and (c) measures of change based on the therapeutic process and various external criteria. Hunt believes that such programmatic research, difficult as it would be in execution, offers the best possibility of evaluating different approaches in therapy.

Such research programs as outlined above, both theoretical and practical, would seem to be the next step toward gaining a greater understanding into the problem of psychotherapy.

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